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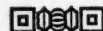
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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—5TH YEAR.

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No. 24.

ONE OF THE PROBLEMS OF PEACE: MENTAL DEFICIENCY.¹

By R. J. A. Berry, M.D., F.R.C.S., F.R.S. (Ed.),
Retiring President of the Victorian Branch of the
British Medical Association.

I do not think I could more fittingly celebrate the most far-reaching and glorious event in my second year of office as President of this Branch than by quoting from William Wetmore Story's "*To Victis*":

"They only the victory win
Who have fought the good fight. . . .
Who have held to their faith unswayed by the prize that
the world holds on high;
Who have dared for a high cause to suffer, resist, fight—
if need be, to die."

On November 11, 1918, the world recovered its freedom, and for that priceless possession we are indebted to the valour of our men and the heroism of our women. That we may never abuse the liberty we have won, and that we may humbly remember that to the inscrutable ways of Almighty God we owe the victory which it has pleased Him to vouchsafe us, must surely be the heartfelt and silent prayer of all.

But what of the cost? "Lord God, we ha' paid it in." Never before in history has there been such an outpouring of human blood as in this greatest and cruellest of cruel wars.

"These heroes are dead. They died for liberty—they died for us. They are at rest. They sleep in the land they made free, under the flag they rendered stainless, under the solemn pines, the sad hemlocks, the tearful willows, the embracing vines. They sleep beneath the shadows of the clouds, careless alike of sunshine or storm, each in the windowless palace of rest. Earth may run red with other wars—they are at peace. In the midst of battles, in the roar of conflict, they found the serenity of death." (Robert Green Ingersoll's "Memorial Day Vision.")

Ladies and Gentlemen, I ask you to rise from your seats as a tribute of respect to our immortal dead.

My next duty is to express to the members of this Branch, who have served their King and country at home and abroad, our most profound and grateful thanks. It is the bounden duty of every member of this Branch to see to it, to make it his personal duty, that these men do not suffer in any way on their return to civilian life and practice. Let us remember this duty now and always.

It is, therefore, a peculiarly fitting and graceful tribute that the Council and members should have unanimously chosen as their President, Lieutenant-Colonel J. Ramsay Webb—a returned soldier, who has seen service in Egypt, England and France, who has made the greatest sacrifices to carry out what he conceived, from the highest motives of patriotism, to be his simple duty. A respected practitioner, a returned soldier, an expert in the conditions of medical

contract practice, a long-standing and valuable member of Council, the Victorian Branch of the British Medical Association may well elect to serve faithfully and loyally under his banner of leadership.

To the Council, Dr. W. R. Boyd, and the members of the Organization Committee, we owe much, more than we are ever likely to realize or repay. The protracted negotiations with the friendly societies have necessitated an unprecedented number of meetings, and the most difficult diplomacy. The conduct of these negotiations may, or may not, have given you entire satisfaction, but whether you pose as critics or not, you may at least unite in recognizing that the only motive which has actuated your Council throughout has been the attainment of the best interests of the profession.

Through your kindness and loyalty and the forbearance of the Council, the retiring President has been enabled to occupy the Presidential chair for the longest period of time in the annals of the Branch, and of this record he is not unjustly proud. His only regret is that the double event of victory in the war and peace with the friendly societies has just failed to materialize in his term of office.

Twelve months ago I deemed it my duty, as a scientific and non-practising member of the profession, to lay before you one of the medical problems of peace. To-night I again propose to direct your attention to a post-war medical problem, for the solution of which the community looks to the profession for light and leading, and on which I can speak with the weight of authority inasmuch as it has occupied almost the whole of my professional time during the last few years. I refer to the subject of mental deficiency.

The war has thrown a lurid light on the many evils and dangers threatening the social fabric, and it is clear that post-war reconstruction will depend on the mentality and efficiency of the people. This being so, it follows that any community which comprises an appreciable percentage of unrecognized mentally deficient persons, will be handicapped in the work of social reconstruction, unless the moron can be recognized and treated.

The term "moron"—derived from the Greek, *μωρός*, a fool—is of comparatively recent introduction into medical science. It is employed in America to designate almost exactly what is meant by "feeble-minded" in England.

Feeble-mindedness or morosity has been variously defined. The legal definition as given in Clause I. of the *Mental Deficiency Act* of 1913, England, is:—

"Persons in whose case there exists from birth, or from an early age, mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision, and control for their own protection or others."

Tredgold, an English medical authority, suggests a definition based on industrial ability. He says:—

"The term mental deficiency, in my opinion, should be restricted to those persons who are so lacking in

¹ An Address Delivered at the Annual General Meeting of the Victorian Branch of the British Medical Association on December 4, 1918.

general mental capacity, and in common sense, that they are incapable of subsisting by their own unaided efforts."

The British Royal Commission in 1908 defined feeble-mindedness as "a state of mental defect from birth, or from an early age, due to incomplete cerebral development, in consequence of which the person affected is unable to perform his duties as a member of society in the position of life to which he was born."

Whilst it is possible to cavil at any of these definitions the last is the least objectionable, because it definitely recognizes the physical basis underlying the condition, and further recognizes that an individual may be regarded as feeble-minded in some walks of life and normal in others. It is this last fact which makes it so difficult to devise a wholly satisfactory or universally applicable definition of feeble-mindedness; this difficulty is an ever-present one, and will probably remain so.

Whilst it is not, therefore, possible to define the precise grade of mental retardation, it has hitherto been customary to endeavour to do so, by expressing it in terms of years. The American Association for the Study of the Feeble-minded has adopted the following scheme:—

The term "idiot" is used to designate those adults up to and including a mental age of two years.

The term "imbecile" denotes those adults of a mental age, from three to seven years inclusive.

For those of a mental age of from seven to twelve years a new term has been coined, namely that of moron, which, as has been stated, is the almost exact equivalent of the English "feeble-minded."

The British Royal Commission on the Care and Control of the Feeble-minded, 1908, in their voluminous report, adopt a somewhat different procedure, and one which might apparently have been modified had the important recent neurological work on the lamination and significance of the *cortex cerebri* been then available. In clause 18 it is stated.

The words "mentally defective" are used in this Report to represent the whole group of cases that come within the scope of our investigation, whether at the present time they can or cannot be certified under the *Lunacy and Idiots Acts*. This group, the "mentally defective," divides itself into two classes. It consists, firstly, of those who from disorder of the mind, or through mental infirmity arising from age or from the decay of their faculties, have lost the power of managing themselves or their affairs. Secondly, it consists of those in whom the brain is in some degree undeveloped, and will remain undeveloped throughout life.

The former class consists, of two sections. In the first of these are included those, who from disorder of the mind, have lost the power of managing themselves or their affairs. To these, the name "lunatic" has hitherto been given by law and popular usage. Adopting a recognized alternative, we would substitute for that word the term "person of unsound mind."

In the second of these sections come those who through mental infirmity arising from age, or from the decay of their faculties, have lost the power of managing themselves or their affairs. To them we would apply the term "mentally infirm." This whole class may be said to consist of persons who have at some time been normal in mind, but have become abnormal.

The latter class comprises those in whom the brain is in some degree undeveloped, and will remain undeveloped throughout life; to this class such terms as idiot, imbecile, feeble-minded and moral imbecile have been generally and somewhat indiscriminately applied.

It will be clear that the British Royal Commission's enquiry covers the whole field of mental disease and abnormality. This field, in so far as the lunatic, or person of unsound mind is concerned, is very efficiently dealt with, by both the community and the profession, but as regards the mentally subnormal, it has hitherto been totally ignored by the State, and but little appreciated by medical men. It is with this last that I am specially concerned, and to which the researches of the last few years have been specially devoted.

The group includes all those persons, not the subject of mental disease, in whom normal cerebral development has been totally or partially arrested at a premature period. It includes, according to the Commission already mentioned, idiots, imbeciles, feeble-minded, epileptics, inebriates, and deaf and dumb or blind. The reasons for the inclusion of these several groups are to be found in the British Commission's definitions, which are as follow:—

Idiot, i.e., persons so deeply defective in mind from birth or from early age that they are unable to guard themselves from common physical dangers, such as, in the case of young children, would prevent their parents from leaving them alone.

Imbeciles, i.e., persons who are capable of guarding themselves against common physical dangers, but who are incapable of earning their own living, by reason of mental defect existing from birth or from an early age.

Feeble-minded, i.e., persons who may be capable of earning a living under favourable circumstances, but are incapable from mental defect existing from birth or from an early age (a) of competing on equal terms with their normal fellows; or (b) of managing themselves and their affairs with ordinary prudence.

Moral imbeciles, i.e., persons who, from an early age, display some mental defect, coupled with strong vicious or criminal propensities, on which punishment has little or no deterrent effect.

Epileptics, i.e., persons who, being epileptic, are also mentally defective.

Inebriates, i.e., persons who, being inebriates, are also mentally defective.

Deaf and dumb or blind, i.e., persons who, being deaf and dumb or blind, are also mentally defective.

The definitions of two of the most interesting of these groups—the feeble-minded and the moral imbecile—were supplemented by Sir James Crichton-Browne as follow:—

A feeble-minded person is one who, by reason of arrested development or disease of the brain, dating from birth or from some age short of maturity, has his observing and reasoning faculties partially weakened, so that he is slow or unsteady in his mental operations, and falls short of ordinary standards of prudence, independence and self-control.

The moral imbecile is a person who, by reason of arrested development or disease of the brain, dating from birth or early years, displays at an early age vicious or criminal propensities, which are of an incorrigible or unusual nature, and are generally associated with some slight limitation of intellect.

It should be particularly noted that in each of these cases the definition specifically mentions arrested mental development as the primary cause of the condition. The chief contribution; which my colleague, Mr. S. D. Porteus, and I have made to this subject, is that we have shown that this degree of arrest can be estimated, and gauged with a reasonable amount of accuracy.

It is a general, though little thought of truth that all children are born idiots, and pass in their development through all the successive stages of imbecility,

morosity, dull normality, to normality and beyond, even to great all-round genius. The degree of feeble-mindedness depends, therefore, not only on the point at which this natural development is arrested, but on whether that arrest is complete or partial. If there be a general arrest of cerebral growth there will be an undoubted and easily recognizable degree of morosity or idiocy. If, however, there be but a partial arrest of cerebral development there will occur those much more complex cases of feeble-mindedness in one direction and normality in another. These last cases naturally call for the greatest diagnostic skill.

Of the many classifications of mental subnormality which have hitherto been attempted, those which have found most favour have been based, as has already been stated, on the psychological phenomena of mental age. Of these that of Healy is as good as any, and is herewith given:—

A.—Mental Defectives.

(1) Feeble-minded.

Idiots: Binet, to 2 years.

Imbeciles: Binet, 2 to 7 years.

Morons: Binet, 7 to 12 years, unless special capabilities making for social success.

- (a) Generally defective.
- (b) Having special abilities which do not make for social success.
- (c) Having apparently, and some times actually, some special ability, such as a good insight into his own defect, language ability, or motor ability, making for social success.

(2) Mentally subnormal.

B.—Individuals defective in special and limited abilities only, otherwise mentally normal.

- (1) Defective ability not interfering with social success.
- (2) Interfering with social success in some defective ability, such as:—
 - (a) Arithmetic
 - (b) Language.
 - (c) Judgement: powers of mental analysis.
 - (d) Self-control.

The recognition of the idiot and the imbecile presents no difficulties in diagnosis, and society is in no doubt as to its treatment, it simply segregates them.

It is the moron who is the real difficulty, and who constitutes the real post-war reconstructional problem. The first point to be emphasized is that such people cannot be recognized from their physical appearance. The most dangerous group of mental defectives are those who are in no way different from the intelligent man, and not only in outward appearance, but in conversation and bearing, these people often pass for normal. They are thought to be simply untutored, and it is supposed that training will bring them up to standard. But that such is not the case

is testified to by the presence of hundreds of such cases in institutions for the feeble-minded, and by thousands of others who are not in such institutions, but who are recognized by those who know the feeble-minded as being mentally deficient. It must further be noted that those forms of amentia, such as idiocy and imbecility, which are easily recognizable, even by a layman, constitute but a very small percentage of the mentally subnormal. At least 70% can only be diagnosed by experts specially trained in the latest methods of neurology and psychological science, and for this the Australian universities have as yet made little or no provision.

Of the causes, heredity is by far the most frequent and the most potent predisposing cause of feeble-mindedness and other forms of nervous and mental disease. What the child inherits is not so much a disease as an unstable nervous system, and in feeble-mindedness the influence of heredity is so potent that even if only one parent is mentally retarded, the children will rarely be up to the normal standard. Where both parents are defective there is no escape.

The British Royal Commission thus sums up the evidence as regards causation of mental subnormality:—

(1) That both on the grounds of fact and of theory there is the highest degree of probability that "feeble-mindedness" is usually spontaneous in origin—that is not due to influences acting on the parent—and tends strongly to be inherited.

(2) That, especially in view of the evidence concerning fertility, the prevention of mentally defective persons becoming parents would tend largely to diminish the number of such persons in the population.

(3) That the evidence for these conclusions strongly supports measures, which on other grounds are of pressing importance, for placing mentally defective persons, men and women, who are living at large and uncontrolled, in institutions where they will be employed and detained; and in this, and in other ways, kept under effectual supervision so long as may be necessary.

In the opinion of the Commission the time is not yet ripe for the prevention of hereditary transmission of mental defect by surgical or other artificial measures.

The next question that arises is, are the mentally subnormal in sufficient numbers in our midst as to constitute a social danger? In a report just issued by the Transvaal Education Department, on Mentally Defective Children in Government Schools, there occur the following statements:—

The British Royal Commission on the feeble-minded found a percentage of 0.86 of the entire school-going population of England and Wales mentally defective, and a percentage of 0.36 of the entire population. According to Karl Pearson the percentage for the entire population is really 0.46. Goddard found nearly 2% of the school-going population in certain districts in America mentally defective.

To the careless or casual thinker these percentages may seem to be so small as to be entirely negligible. Such a view is as short sighted as it is erroneous. First, it must be remembered that such percentages are calculated from imperfect methods of diagnosis, and that with more perfected means of diagnosis the percentages of feeble-minded will be found to be higher. Second, the danger to the community cannot be estimated from a mere study of the incidence of

morosity, as is again shown by the following extract from the South African Report:—

In certain American reformatories the percentage of defectives was found by Goddard to be between 46% and 89%. In a Reformatory for Prostitutes Bridgeman found the percentage—obtained by the Binet test alone—as high as 97%. Of the inmates of workhouses 50% have been found to be mentally defective. Among prostitutes the percentage is also 50%. Donkin found 10% to 20% mentally defective among a group of convicted criminals, while Braithwaite found 60% among offenders against the *Inebriates Act*.

This extract should suffice to convince every thoughtful person that the danger and cost to the community of the moron are out of all proportion to the incidence of the condition. In a democratic community with universal adult suffrage the dangers are enhanced. It is now known that grave national issues have been decided by majorities within the known incidence, if not of morosity, certainly of mental subnormality. There can thus be little or no question of the truth of Professor Karl Pearson's dictum, published in 1914, that "we have to see that we are really on the fringe of the biggest problem of the modern state—the question of social inefficiency."

Heretofore the diagnosis of mental subnormality has been based almost exclusively on the application of certain well-known and approved "intelligence tests." Recognizing that there was considerable room for improvement in the mode of diagnosis of the mentally subnormal, as also in the study of the individual normal or merely educationally backward child, my colleague, Mr. S. D. Porteus, and I have devoted a prolonged period of time to an exhaustive study of the problem. Our conjoint researches have proceeded on three main lines:—

- (1) A neurological examination of about 10,000 presumably normal school children with controls drawn from known abnormal sources.
- (2) A mental examination of about 2,500 presumably normal school children with controls drawn from known abnormal sources.
- (3) An attentive study of the work of other observers in Great Britain, America, South Africa, Canada, France and Italy.

We have had the further advantage of a close association between the neurologist and the psychologist skilled in the observation and training of the feeble-minded, and, lastly, we have had every possible assistance from the educational authorities, both State and private, as also from those members of the medical profession whom it has so frequently been necessary to consult. To all these we tender our most grateful thanks, as also to the Directors of *The Herald* and *Weekly Times*, for their generous financial assistance. The result of these researches will be published in due course. Here it must suffice to say that, as a result of this investigation, we have evolved a combination method of diagnosis of mental subnormality, which we venture to assert is an advance on those already existing.

Recognizing that the problem of mental subnormality is an extremely complex one, the authors' combination method of diagnosis assumes a definition which is at once physical, psychological and social, and thus endeavours to attack the problem from every

side. It seeks to base a diagnosis of potential social inefficiency on the following considerations:—

- (1) Physical: the brain.—Are there signs of incomplete cerebral development?
- (2) Psycho-physical: the body.—Are there any remediable physical conditions interfering with complete cerebral development?
- (3) Psychological: the mind.—What is the social significance of the mental retardation?
- (4) Educational and social: the environment.—Has the individual succeeded in adjusting himself to his environment?

It cannot be sufficiently emphasized that the method we advocate and employ is a combination method, and is intended to be employed in its entirety, and not in sections. It is precisely this combination of avenues of approach which makes the method an advance on its predecessors; whilst a further advance is made by the recognition of the fact that, since the brain is the physical organ of mind, attention must be prominently directed to its stage of development, a point on which the British Royal Commission has everywhere insisted.

Recent histological and neurological research by Bolton, Mott, Watson, and others, has shown the deep significance of the infra-granular (or instinctive) and supra-granular (or educational and controlling) layers of the *cortex cerebri*. The former is the layer of all the animal instincts. Of the latter, J. S. Bolton says:—

The supra-granular layer is the most prominent feature of the human cortex, and constitutes a "higher level" basis for the carrying on of the cerebral functions. It is the last layer of the cortex to be evolved, the last to commence to develop, the last to attain maturity, and, consequently, the first to undergo retrogression. It is the only cell layer of the cerebral cortex which varies definitely in measurable depth in normal brains. It is underdeveloped to different degrees, according to the mental capacity of the individual, in persons exhibiting various grades of mental subevolution, and it undergoes degrees of retrogression, which correspond to the amount of dementia existing in cases which permanently suffer from diminution or loss of their mental powers.

The shape and size of the head depend on the shape and size of the brain, and the size and strength of the muscles which arise from the skull. Of these two factors brain growth is by far the more important, and muscular action only exercises a minor influence. In an ordinary normal human brain there should be some 9,000 million neurones. Assuming that only one-third of these belong to the supra-granular layer, it should be obvious that if they fail to develop, or their axons to myelinate, the individual will not only have a much smaller brain, but will also have a smaller head, which can be detected in life, and its significance, if any, determined by mental and other tests. It should also be clear that in such a case the individual cannot possess a normal intelligence, but will have the instincts of the brute, with about as much control over those animal instincts as any other animal.

In the authors' combination method head measurement is employed, not as a measure of intelligence, but as a first and rough estimate of the stage of cerebral development attained. From our own investigations we now know what those stages should be at every period of educational life. Whilst nothing is

as yet known of the relative or varying ratios of neurone and neuroglia, it necessarily follows that abnormally sized heads are not necessarily indicative of either feeble-mindedness or genius, but it is equally certain that a very large proportion of the mentally deficient have abnormally sized heads, and hence of all the ancillary methods of diagnosis of feeble-mindedness, an investigation of head form, in so far as it throws light on the degree of cerebral development attained, is easily one of the best. Its real significance is that it affords, in certain cases, an indication of the development in the growing boy or girl of the all important supra-granular layer of the cortex. As regards the psychological tests employed in the authors' combination method, chief use is made of the Binet-Simon and Porteus tests, for the simple reason that these have both been standardized, and, in combination with our other avenues of approach, are often sufficient to establish the diagnosis. In difficult cases other tests, such as the Knox, Healy, and others are also used. It is obviously a waste of time to employ psychological tests which have not been standardized, and which, therefore, give no indication of the individual's mental level in comparison with normal people. There is here a very large field for future research, particularly as regards normal children, which cannot fail to be of service to the educationalist.

The two following cases will suffice to illustrate the authors' combination method of diagnosis in actual working operation.

Case I.—Male, aged 18 years. Inmate of the Castle-maine Reformatory for Indeterminate Sentence Criminals.

The crime.—Convicted as a habitual offender. Awarded an indeterminate sentence. His last crime was setting fire to a house with intent to watch the inmates burn.

Physical examination: the brain.—Falls below the 10 percentile of his group, with a cubic capacity of 1,248 c.cm., which suggests imperfect development of the controlling supra-granular cortical layer.

Psycho-physical examination: the body.—Weight, height, grip and vital capacity are all below the 10 percentile of his age group.

Psychological examination: the mind.—Porteus tests give a mental age of 7 years. No capacity for forethought and highly suggestible. Binet tests also give a mental age of 7 years. Cannot recognize the four colours, red, blue, yellow and green. Cannot repeat five numerals, nor count backwards from 20, nor perform the simplest money operations.

Educational and social: the environment.—Can neither read nor write. Delicate health in childhood. Father a woodcutter. Boy assisted his father until conviction.

Diagnosis.—A high grade imbecile. Mental condition not apparently recognized until the time of expert examination. Utterly unfitted to be at large, but quite irresponsible for his crimes, on account of seriously arrested cerebral development.

Case II.—Male, aged 15 years. Melbourne Public School boy.

Clinical history.—Infantile paralysis at 18 months. Convulsions in infancy. Partial right sided hemi-

plegia. Sexual characteristics and habits over-developed.

Physical examination: the brain.—Falls below the 10 percentile of his age group, with a cubic capacity of 1,095 c.cm., which is about the level of a two to three-year old child.

Psycho-physical examination: the body.—Weight, stature, and sitting height slightly above normal, with an average percentile of 63. Vital capacity, right and left grip below normal, with an average percentile of 32.

Psychological examination: the mind.—Porteus tests give a mental age of 8 years. No planning capacity or foresight. Impulsive and imprudent. Binet tests also give a mental age of 8 years. Weak in ability to memorize, to sustain attention, with a very narrow range of ideas.

Educational and social: the environment.—Has no interest in school work, and has made little progress in arithmetic and reading. At 15 years of age is still in the preparatory grade with boys of 8 and 9 years. Lies, steals, a sex offender, and a prey to every impulse. Is of good family and of wealthy parents; he consequently lacks nothing, but acquires everything he takes a fancy to, and has already been in the hands of the police.

Diagnosis.—A moron of low grade. Deficiency due to cerebral under-development following paralysis. Morally irresponsible.

Prognosis.—Under different environmental conditions a criminal and a social inefficient. Society has been saved from the depredations of a future criminal only because the parents have been willing, and were financially able, to follow expert advice and guidance. The real significance of this case lies in the fact that mental deficiency, as the cause of the boy's unsatisfactory school history, had not been recognized until the Headmaster put our advice to the practical test. He now systematically causes every boy's cubic capacity to be estimated and, on the results attained in this case, advised the parents to consult us.

It is not yet nearly sufficiently recognized that all children of a given age are not equally advanced in a physiological sense. The number of years a child has lived is his "chronological age." In contra-distinction to this, the stage of maturity, mental physical or sexual, which the child has attained, is his "physiological age." Differences between the chronological and physiological ages may, and frequently do, persist into adult life, and as regards the brain are responsible for the marked individual intellectual differences. Society has, therefore, no moral right to turn over the weakly immature or mental child to the overtaxing work of mill or factory, on the mere basis of so many years lived. It consequently follows that closer investigation of the relations existing between the anatomical, physiological and mental ages of children is one of the urgent problems of educational hygiene.

In this essential work of post-war educational and social reconstruction, without which no community can expect to make good the terrible ravages of war, there are thus two great fields for research and investigation.

The one, with which we are specially concerned, is

the recognition and elimination of the mentally subnormal. The other and larger field is amongst the normal school population. The former requires the co-operation of the medical profession, the educationist and the psychologist. The latter more particularly concerns the last two and the school medical officer. Both divisions should be co-ordinated in a child study clinic.

Of the importance of the whole problem of the mentally subnormal or socially inefficient to the community, there is no question.

Dr. William Healy, writing in 1915, says: "The gist of the situation is that mental defect forms the largest single cause of delinquency."

Goddard finds in American reformatories and gaols percentages of feeble-mindedness ranging from 28% to 89%.

In the Castlemaine Reformatory (Victoria) the prisoners have an average age of 19 years, but an average physical and mental age of only from 10 to 12 years.

Of 33 criminals hanged in Melbourne for murder, only 7 were found to be at normal levels, as regards cubic capacity of brain.

In every community prostitutes and criminals are largely recruited from the ranks of the feeble-minded, but, unfortunately, the danger to society does not stop at this.

Dr. Goddard says: "Every soldier is liable to have sentry duty. . . . in such a position a moron would be a man of clay. He might be tricked into betraying the whole camp."

At a moderate computation the Commonwealth of Australia has enlisted one moron a month from the six States, and has thereby wasted some £20,000 per annum since the outbreak of war. On this one item alone expert assistance could have saved the Commonwealth taxpayer from £50,000 to £70,000.

Writing in 1917, Dr. M. P. E. Groszman says: "It costs the citizens of the United States 1,100 million dollars a year for police, courts of justice, prisons, charities, houses of correction, and similar forms of self-protection against the festering human refuse heap. . . . It is a curious fact that the nation is spending only 600 million dollars annually for schools, churches and other constructive agencies. In other words, 500 million dollars less is spent to develop human assets than is spent to keep up the human failures."

What then is the solution of what Professor Pearson terms "the biggest problem of the modern State?"

To us it would appear there is urgently wanted in Australia a central child study clinic in the first place, and a colony for segregation in the second.

A psychological or child study clinic was established in the University of Pennsylvania so far back as 1897, in answer to a direct call from the educational world. Its functions are:—

- (1) To investigate the phenomena of mental development in school children, as manifested more particularly in mental and moral retardation, by means of the statistical and clinical methods.
- (2) To establish a child study clinic supple-

mented by a training school in the nature of a hospital school, for the treatment of all classes of children suffering from mental retardation, or physical defects interfering with school progress.

- (3) To offer practical work to those engaged in the professions of teaching and medicine, and to those interested in social work, in the observation and training of normal and retarded children.
- (4) To train students for a new profession—that of child study expert, who would find his career in connexion with the school system, through the examination and treatment of mentally and morally retarded children, or in connexion with the practice of medicine.

In view of the complexity of the problems with which such a clinic would have to deal, it would necessarily base its policy on a thorough-going principle of co-operation, and would seek to associate with it in an advisory and consulting capacity, a carefully selected board of medical men, educationists and psychologists. It would undertake the examination, not only of the mentally deficient child, but also of normal and exceptionally brilliant children. It would thus centralize research in both neurology and psychology.

The question naturally arises, what would it cost? The reply is that its cost is a mere drop in the ocean compared to what it would save.

The industrial world has long since learned that in the process of converting raw material into a finished product waste must be reduced to a minimum. We are beginning to discover that one of the most important raw materials—the human material—is being most wastefully treated. The business of life needs to be placed on the basis of efficiency. The saving is not merely one of money, but what is vastly more important, human souls.

The real need is for research. Only through research can scientific knowledge take the place of unverified opinions, and only through scientific knowledge can practical efficiency be attained.

The children of to-day are the real wealth of the nation. Is then their future to depend on the unverified opinions of an amateur, superficial and bungling decade, or is it to be the product of scientific research and knowledge?

Reports of Cases.

TWO CASES OF PRIMARY PNEUMOCOCCAL MENINGITIS.

By Glen H. Burnell, M.B., B.S.,
Broken Hill.

Pneumococcal meningitis as a primary condition is sufficiently rare to make a record of these two cases of interest. In the literature available to the writer, the only reference to it as a separate entity is in Osler and McCrae's "System of Medicine" and Latham and English's "Treatment." The former work states merely that "pneumococcal meningitis may occur as a primary condition," while the latter devotes a few lines to treatment.

Case I.—G.B., *et. 5½* years, male, was admitted to hos-

pital on October 3, 1918, with the following history. He was quite well until September 30, 1918. During that day he complained of aching of the top of the head. He had several screaming fits during that night. On October 1, 1918, he vomited several times. The vomiting was independent of the taking of food.

On October 2, 1918, he became delirious and very restless, tossing constantly on the bed. He was given some calomel (amount unknown), and had four green motions on October 3, 1918, before admission to hospital. There was no previous history of ear trouble or of cough. The child was extremely restless and calling out incessantly. Photophobia was well marked. The temperature was 38.3°C ., the pulse-rate 120 and the respiratory-rate 42. There was definite rigidity of the neck. The pupils reacted briskly to light. The lungs were carefully examined, but nothing abnormal was detected. The spleen was not enlarged. The knee jerks were equal and active. Kernig's sign was well marked. The superficial reflexes were absent. A lumbar puncture was done, and 20 c.cm. of a slightly turbid fluid, with a greenish tinge, and not under pressure, were obtained. At the same time 15 c.cm. of anti-meningococcal serum were injected into the spinal theca, and 10 c.cm. subcutaneously, the writer supposing it to be a case of meningococcal meningitis.

A cell count of the spinal fluid gave 280 per cubic millimetre, mostly lymphocytes.

A blood count showed 28,000 leucocytes per c.mm., and a differential count showed:—

Polymorpho-nuclear cells	90%
Lymphocytes	4%
Transitional cells	6%

In doing the cell count of the spinal fluid, myriads of organisms were observed in it, and stained films and cultures on blood agar showed these to be pneumococci. In a film taken without centrifuging, the whole field was simply smothered with pneumococci. This proved the case to be a pneumococcal meningitis, either primary or secondary, and the lungs were again examined without result.

The writer has been interested in following up the work of Lister in South Africa, on the strains of pneumococci, and so had a series of sera taken from pneumonia patients after their crises. These were all tested against the organism in question and only one found to agglutinate it strongly, but unfortunately the patient from whom this had been taken had by this time developed an empyema and was in no condition to stand any further loss of blood. Falling this, 20 c.cm. of a non-agglutinating serum were injected subcutaneously at 4 p.m. on October 3, 1918.

The patient's condition went steadily down, and he died at 10 p.m.

Permission for a post-mortem examination was not obtained, so I was unable to verify the diagnosis of it being a truly primary condition; but in the next case I was more fortunate.

Case II.—Mrs. M.A.M., *et.* 58 years, was admitted on October 12, 1918.

The history was as follows: On October 9, 1918, during the evening, she complained of slight headache, but slept as usual that night. On October 10, 1918, she began to vomit frequently, and became delirious. She was not seen by a medical man until October 12, 1918. He found the bladder much distended, catheterized the patient and sent her into hospital with the diagnosis of meningitis.

The only fact of interest in the previous history was that she slipped and struck the right side of her head two days before the onset of the illness.

On admission the patient was found to be very restless and noisy. She was a very stout woman, with flushed face. She resisted strongly all efforts to examine her. Her temperature was 38.8°C ., her pulse-rate 104, and her respiratory-rate 36. The pupils were semi-dilated; no reaction to light was obtained. The neck was very rigid, but there was no retraction. The tongue was dry and brown. The heart, lungs and abdomen appeared to be normal. The knee-jerks were present, but were more active on the left side; the plantar reflex was absent. She had a well-marked Kernig's sign.

A blood count showed leucocytes 18,000, and a differential count:—

Polymorpho-nuclear leucocytes	82%
Lymphocytes	11%
Transitional forms	7%

Under chloroform a lumbar puncture was done and 15 c.cm. of a hazy fluid withdrawn. The intra-spinal pressure was not increased. The fluid had a greenish appearance, making one suspicious by its resemblance to the fluid in the previous case, but as the writer did not wish to lose any time, he gave her 30 c.cm. antimeningococcal serum into the spinal theca and 10 c.cm. intramuscularly. On examining the spinal fluid half an hour later myriads of pneumococci were again seen. On blood agar a pure culture of pneumococcus was obtained.

A cell count of the spinal fluid revealed 750 cells per c.mm.; 59% were polymorpho-nuclear cells and 41% lymphocytes. As in the former case, the writer tested this strain of pneumococcus with regard to its agglutinating properties and found a serum that agglutinated it strongly.



Figure I.
Portion of the Dorsal Cord. At "A" is a small hæmorrhage in the white matter.

Accordingly, a second puncture was done four hours after the first; the canal was washed out with warm saline solution and 15 c.cm. of anti-pneumococcal serum were injected, at the same time 12 c.cm. were given subcutaneously.

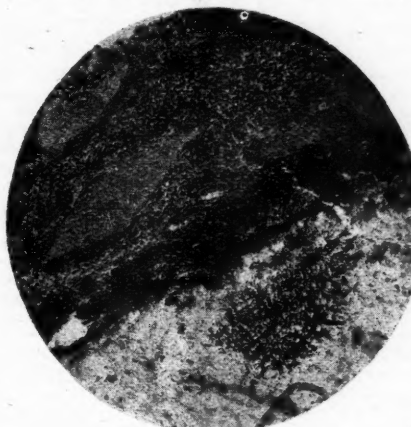


Figure II.

The temperature at this stage was 41.1°C . Two hours later the pulse became weak and thready, and she died eleven hours after admission to hospital. A post-mortem examination showed the lungs to be normal to the naked eye. There was some enlargement of the liver. The kidneys were normal and the spleen was not enlarged but very friable. The brain was not examined, but the spinal cord was exposed throughout its whole extent. The meninges showed intense injection, and the cord tissue itself appeared unduly soft and "mushy." It is a fair presumption that the changes in the cerebral meninges, although probably more advanced, were similar to those of the spinal meninges.

Sections showed a diffuse fatty degeneration of the liver, while those of the cord in the mid-dorsal region (Fig. I.) showed an extreme degree of round-celled infiltration of the pia-arachnoid, with a few scattered hemorrhages in the white matter of the cord itself. The grey matter of the cord was normal. Fig. II. is a portion of Fig. I. under a higher power.

On October 15, 1918, a rabbit was injected intravenously with the first subculture on blood agar (48 hours' growth). It was apparently well on October 23, 1918, when it was re-injected intravenously with the second subculture on blood agar (24 hours' growth). It became ill on October 26, 1918, and died on October 28, 1918. *Post mortem* all organs were macroscopically normal, except the central nervous system, which showed a marked congestion of the pia-arachnoid. Smears taken from the cerebro-spinal fluid showed a great excess of leucocytes, all lymphocytes, while cultures of the fluid and of the heart's blood on blood-agar gave pneumococci.

The ultimate diagnosis could only be made by a microscopical examination, but in future a greenish tinge of the spinal fluid would make the writer strongly suspect a pneumococcal infection.

I wish to thank the Superintendent, Dr. Birks, for permission to publish these cases.

PERFORATING INJURY OF BOTH EYES.¹

By J. Lockhart Gibson, M.D. (Edin.),

Consulting Ophthalmologist, First Military District, Brisbane.

The case of Private M., aged 34, is shown to-night as an example of how nearly a man at the front may be blown to pieces and made blind, and still escape with useful limbs, a good throat and excellent sight. The right thigh and knee were badly smashed, and the knee is permanently ankylosed, and there is still some foot-drop. The left hand has lost three fingers. Each shoulder was injured, and there is a large scar over the thyroid cartilage, showing where the larynx was injured. There are small foreign bodies and powder marks all over his face, especially about his eyes and temples. There were foreign bodies in both orbits, and almost certainly a foreign body has gone through each eye, taking the lens in transit.

He was wounded on April 11, 1916, by an explosive shell. I saw him in July, 1918, when his eyes showed the following: Right eye, two or three small scars, and one two millimetres long, nearly central scar, in the cornea. Also a stained one-millimetre scar on the lower inner side of the pupil. A two-millimetre hole in the lower iris, as if caused by the passage of a foreign body, now closed with organized exudation. Occupying the pupil is the thick membranous remains of a traumatic cataract, to which the edges of the pupil are attached below. The upper part of this membrane is thin and admits some light. Corrected vision was $\frac{1}{200}$. One of the foreign bodies shown by X-rays appeared to be in the vitreous chamber, but is probably in the outer coats of the eye posteriorly. Left eye, a large, nearly central, two-millimetre scar in the cornea. There were some dark spots on the cornea and under the ocular conjunctiva, either powder grains or small foreign bodies. Occupying the pupil were dense, membranous remains of a traumatic cataract. One part was thin and admitting some light. Corrected vision was $\frac{1}{200}$. One of the foreign bodies shown by X-rays appeared to be either in the vitreous chamber or in the outer coats of the eye. Probably the latter.

July, 1918.—Needling the right eye obtained a small, but sufficient, hole in the upper part of the cataract remains and without causing any reaction.

September, 1918.—Needling the left eye obtained a sufficient opening in the cataract remains, and without causing any reaction.

Corrected vision is now $\frac{1}{40}$ with the right eye and one or two letters of $\frac{1}{20}$, and $\frac{1}{40}$ with the left eye and one or two letters of $\frac{1}{20}$.

Binocular vision is better than vision with either eye alone.

The clear opening obtained in the membrane occupying the right pupil is small, and it is impossible to see all the fundus well. There is a small area in the upper outer quadrant of the fundus, which could be the scar left by the passage of a small foreign body. A more complete view is obtained of the left fundus, but no scar can be seen in it. If there is one it is in the periphery of the fundus.

There is no staining or siderosis of either eye, and no sign of present irritation. On the principle of "letting sleeping dogs lie" I did not apply either eye to the giant magnet. After two years it is fair to assume that any steel foreign body in contact with the fluids of an eye would have set up some sign of siderosis.

It is likely that the vision obtained will persist. The result now obtained is largely due to the masterly inactivity of those who had the care of this case on the other side.

Reviews.

TREATMENT OF INSANITY.

Dr. Bernard Hart has published in booklet form¹ a lecture which he delivered at the University of Manchester on March 25, 1918. The subject is "The Modern Treatment of Mental and Nervous Disorders," and his audience was apparently composed of students, as he told them that: "It is, moreover, a highly technical field, requiring for its adequate understanding a theoretical and practical knowledge of medicine, which I cannot assume my present audience to possess." Dr. Hart explains that there are two schools of opinion in regard to the causation of mental disorders, the purely physiological and the purely psychological, and it appears to be the purpose of the lecturer to show that it is a combination of these causes which produce the mental disorder. Sometimes the psychical factor is the chief cause of the mental disturbance, and sometimes it is the physiological. It is really another way of saying that heredity and stress are the causes of mental disorders, provided that psychical factors, such as grief, worry, etc., are included in "stress." The author cites anxiety as a mental factor causing irritability, in contrast with dyspepsia as a bodily factor in causing the same condition of mind, but he does not proceed to demonstrate the vicious cycle of anxiety producing dyspepsia by inhibition of the digestive juices, and thus acting indirectly as a causative factor in the mental disorder. By a series of diagrams of chains, the links of which represent the factors which come into play in cases of mental disorder, different types of insanity are explained. The most potent factor in each case is represented by an extra large link, and treatment is directed towards the factor which that link represents, in some cases mental and in other cases physical. If the cause be mental, then suggestion and other psychological methods of treatment must be employed, and if the cause be physical, then treatment of the physical ailment must be employed. Like all the advocates of the psychological school, Dr. Hart does not tell us what these psychological factors do to cause the alteration of the ego, and that is what the physiological school has been asking them to explain all along. It is gratifying to see that Dr. Hart does not include the teachings of Freud, Adler, Jung and Jones amongst the mental factors in mental disorders. These gentlemen, in their conception of the causation of insanity, appear to ignore the effect of the mind on the sympathetic system and indirectly on the glandular system of the body. In the last few pages of the booklet the author pleads for the early treatment of borderland cases, to prevent the patients drifting on to the stage when certification to a hospital for insane is imperative. The booklet is well worth reading by those interested in this branch of medicine. Its chief fault is that it had to be condensed into lecture compass. If it were given in more extended form it would be a great improvement and allow the author to go more into detail.

¹ Read at a Meeting of the Queensland Branch of the British Medical Association on October 4, 1918.

¹ The Modern Treatment of Mental and Nervous Disorders, by Bernard Hart, M.D.; 1918. Manchester: The University Press; London: Longmans, Green & Co. Crown 8vo., pp. 28.

The Medical Journal of Australia.

SATURDAY, DECEMBER 14, 1918.

The Lessons of the Lodge Dispute.

The acceptance by the Friendly Societies' Association of Victoria of the ten resolutions as a basis for an agreement between the friendly societies and the lodge surgeons may be regarded as the signature of peace. The final stages will be occupied by negotiations for the adjustment of a few technical and minor points arising from the dispute, but it may be accepted that the main issues have been met, and that the friendly society lodges have now been deprived of the right to make individual bargains with individual medical practitioners. Politicians and the daily press apparently have the desire to disturb the settlement, presumably because they intervened in a dispute which did not concern them, declared themselves as supporters of one or other side, and endeavoured to create a political significance of the affair which was at once artificial and irresponsible. The question may be restated as follows. Medical practitioners recognized that people in poor circumstances could not afford to pay full fees for their services. They, therefore, undertook to give these people medical attendance when necessary in return for a small, regular payment. The lodges took advantage of this generosity and, using the lever of a large number of individual members, played one doctor off against another, in order to drive down the rate of premium. It is not improbable that the medical profession would have suffered without objection, had the beneficiaries been exclusively persons of very small means. The inclusion of relatively prosperous workers in the lodges rendered it essential for the medical profession to resolve that the terms and conditions of lodge practice should be regulated and made uniform. Due regard was had to the financial position of the persons to whom the concession was to be made, and the rates of payment were fixed in

accordance with the existing conditions. One basic principle was introduced, namely, that no concession should be granted to persons financially able to obtain medical attendance in the ordinary way. This is the way in which the medical profession regards contract medical practice. In the future the medical profession will be the sole judges of the terms and conditions under which concessions will be granted to persons unable to pay a doctor's private fees.

The friendly societies apparently regard the matter in a different light. They have become powerful political agencies, and have long since ceased to exist as clubs, having the object of enabling the poorer members of the community to circumvent the financial embarrassment of sickness, invalidity and old age, and the necessity of accepting charity or State assistance when a relative dies and has to be buried. They have political aims and political organizations, and the sickness and medical benefits are merely inducements to swell their membership. In other words, the medical profession was exploited in order that the various orders might become strong and wield powerful influence.

All this is to be altered. We are returning to the conditions of the past, and the medical profession will refuse to be the cat's paw of the politician any longer.

The events of the past few days prove that the Friendly Societies' Association has not the authority over the several orders and lodges necessary to bind them by its resolutions. The determinations arrived at on November 30, 1918, have to be endorsed by the orders and lodges, and in some cases it appears that a confirmation will not be obtained. In these instances the orders or lodges will suffer, for no member of the British Medical Association will enter into an agreement with them, even if the terms are otherwise favourable. There is unity between the doctors, and we expect a similar unity among the lodges.

In the last place, the members of the lodges may rest assured that since the conditions of contract practice have been revised, the service will be better than it has been in the past. The members have a right to expect the best medical attendance from their lodge surgeons. No member, having signed a satisfactory

contract, is justified in performing slovenly work, and in the future both diagnosis and treatment must be of a high order, in keeping with the practice of modern medicine. It may be that within a measurable time, the lists of lodge doctors will be limited, for it is impossible for any practitioner to carry out good work when he has an unreasonably large number of persons to attend.

MENTAL EFFICIENCY AND DEFICIENCY.

The custom obtaining in all the Branches of the British Medical Association in Australia of requiring the retiring President to deliver an address, which is not subjected to discussion or criticism, has resulted in great benefit to the medical profession. In some instances the retiring President restricts himself to a review of the year's work and to the lessons that can be drawn from the many events. In other cases the subject chosen has been the completion of some special activity with which the speaker has associated himself. Matters of scientific importance, large social problems and historical records have also furnished the members with material for fruitful thought and action. On December 4, 1918, Professor R. J. A. Berry, the retiring President of the Victorian Branch, has spoken again of the problem of the mentally subnormal and of the work on which he, together with Mr. S. D. Porteus, has been engaged for some years. He claims on the experience of this investigation that the less evident degrees of mental deficiency are diagnosable by a combination of the measurement of the cubic capacity of the brain, the estimation of the mental standard as judged by the results of the Binet, Porteus and other tests, and the consideration of the child's home and school history. There can be no question as to the urgency of expert diagnosis of retardation of cerebral development. We have abundant evidence of its extreme frequency under ordinary conditions. In addition, as was recently pointed out in these columns, mental deficiency exists in an alarmingly high proportion of the children in North Queensland, where hookworm infestation is common.

Australia, like every other country, has a stern and arduous task to face in post-war reconstruction and

in the endeavour to steer between the dangers of autocratic misrule and uneducated mass domination. The future prosperity and progress of Australia will depend on the mental efficiency not only of those in authority, but also of those who are to mould the industrial and social destinies of the people. We have to relearn the economic value of science, the inestimable worth of efficiency in all undertakings, and the financial and material loss which inevitably follows even a small admixture of mental inefficiency. Add to this the dangers surrounding the irresponsibility of mental deficiency, and the argument in favour of a proper recognition and safe control of those whose mental development is retarded, is full.

Professor Berry's views must be taken into consideration when a definite plan of action is determined upon. There are others who have a right to make their voices heard in the discussions of this problem. There are certain fundamental points on which there is likely to be but little difference of opinion. In the first place, the diagnosis must be left in the hands of medical experts, and must be based in all cases on acceptable signs and symptoms. In the next place the control must be of such a character as to guarantee safety to both the unfortunate sufferer and the rest of the community. In the last place, the steps adopted must be uniform and apply in all parts of the Commonwealth. There are other matters connected with this difficult problem concerning which there may be less unanimity even among those who have studied the subject scientifically. Since this matter is admittedly a highly important one and at the same time an urgent one, it has been thought wise to make an attempt to bring together a large number of men and women from all parts of Australia, to discuss the several aspects of the problem, and to formulate a policy to be put into action with as little delay as possible. If premeditation, ingenuity and sound practical sense are combined and serve to guide the deliberations of the experts and sociologist gathered together for the purpose of liberating Australia from the curse of the mentally deficient, there can be no doubt concerning the national advantage to be gained. A healthy minded community cannot be obtained save by the exclusion of the moron and the mentally subnormal.

VENEREAL DISEASES LEGISLATION IN
NEW SOUTH WALES.

The Venereal Diseases Bill, which was presented to the parliament of New South Wales, is designed to regulate the treatment of venereal diseases, to prevent the spread of such diseases in the community, and to limit certain practices and conditions which are likely to hinder the control of these diseases.¹ The Bill, as drafted, provides that every form of treatment for gonorrhœa, gonorrhœal ophthalmia, syphilis, soft chancre, venereal warts and venereal granuloma shall be prescribed and carried out by a legally qualified medical practitioner registered in New South Wales, or by a person acting under the direct instructions of such a medical practitioner, with the exception of the supply of medicines, which may be furnished by a registered pharmaceutical chemist on the prescription of a medical practitioner, if this script bears the date, the address and the usual signature, including the surname, of the writer. A clause, however, permits the registered pharmacist to attend upon or prescribe for any venereal disease other than syphilis, when such chemist does so in the manner set forth by regulation. A regulation is also to be promulgated, containing a list of the drugs and medicines which may not be sold by chemists, except as dispensed to the patient of a medical practitioner, or as allowed by other regulations under this Act.

All persons suffering from venereal disease, or being suspicious that they are suffering from any of the specified ailments, have to consult a medical practitioner within three days of becoming aware of their condition, or to attend at some hospital or other place where treatment is available. The patients must furnish their correct names and addresses, must follow the advice given to them by their medical attendants, and must continue to apply for treatment until they receive a certificate that they are cured, or are free from venereal disease. The medical attendant has to notify on a prescribed form that the patient is suffering from venereal disease, but the name and address of the patient must not be disclosed. The penalties provided for a contravention of this clause by a medical practitioner are, for a first offence a fine not exceeding twenty pounds, and for a subsequent offence a fine of not less than twenty pounds, but not exceeding one hundred pounds. Patients desirous of changing their medical attendants must continue treatment, and must inform their new medical attendant of the name and address of the medical practitioner that they have been visiting. The medical practitioner so informed must forthwith send to the previous attendant of the patient a notice in the prescribed form. When a patient fails to visit the medical attendant for a period to be prescribed by regulation, the medical attendant must notify the Commissioner administering the Act of the facts in another prescribed form of notice, unless a notification has been received that the patient is attending another medical practitioner. This information to the Commissioner must be placed in a sealed envelope marked confidential.

¹ The full text of the Bill will be published in next week's issue. The Bill has passed through all its stages in both Houses, and awaits assent in the amended form. The amendments will be dealt with in next week's issue.

The medical attendant must deliver a written notice in the prescribed form to the patient, directing attention to the infectious nature of the disease, and to the legal consequences of infecting others, and warning the patient against contracting any marriage until certified under the Act as cured, and he must hand to the patient certain printed, prescribed information about the disease. The parents and guardians of children suffering from venereal diseases, must exercise their authority to compel or induce the children to undergo treatment. The medical attendant has to give the parent or guardian of a child the same instructions that are required to be made to an adult patient. When a patient becomes cured, free from venereal disease, or no longer liable to convey infection, any medical practitioner, on being satisfied, may give to the patient, subject to the conditions of this Act, a certificate in the prescribed form. Such certificates must not be used for any purpose in relation to prostitution. It is made lawful for a medical practitioner having reason to believe that a person suffering from venereal disease is about to contract marriage, to inform the other party to the marriage, or a parent or guardian of such other party, or the Commissioner, that such person is suffering from venereal disease. All persons aware that they are suffering from venereal disease, who marry, are liable to imprisonment for a period not exceeding five years, or to a fine not exceeding five hundred pounds. A fine not exceeding one hundred pounds, or a term of imprisonment for not more than twelve months, is the penalty for knowingly infecting any other person with a venereal disease, or for permitting or suffering any act likely to lead to the infection of any other person.

The medical practitioner who gives without negligence any certificate or notice under this Act, is protected against civil or criminal action in respect to the certificate or notice. All legal proceedings under this Act are confidential, and secrecy is enforced by a heavy penalty upon all persons becoming aware of any matters connected with the administration of this Act. No report of any proceeding or matter held in private under this Act, may be published in any newspaper, though this prohibition does not extend to any reports published on the written authority of the Commissioner.

The Director-General of Public Health, or in the absence of such an officer any medical practitioner appointed by the Governor, is the commissioner under the Act. The owners of houses and the occupiers of houses and rooms are liable to heavy penalties for permitting persons suffering from venereal diseases to occupy houses or rooms for the purpose of prostitution. The managers of hospitals receiving aid from the State must make effective provision for the reception, accommodation, examination and treatment (free of charge) of such persons suffering from venereal disease as are prescribed, under penalty of losing the whole or part of their subsidy. The advertisement of any medicine, instrument or appliance for the alleviation or cure of any venereal disease, with the object of promoting its sale, is forbidden. Magistrates are given power to seize prohibited articles at the request of the Commissioner. The Minister administering this Act may establish hospitals or places

for the reception and treatment of patients suffering from venereal disease, may arrange with medical practitioners for treating persons, and for the remuneration of the medical attendant, may provide, free of charge to the patient, for chemical bacteriological and other examinations, may supply drugs, medicines and appliances to those who are unable to obtain them, and may prepare and distribute information about venereal diseases. No prosecution under this Act can be undertaken, unless with the consent of the Commissioner.

The provisions of this Bill differ from those of the Acts at present in force in the other Australian States in a number of important particulars. In the first place, the Bill gives to registered pharmaceutical chemists the legal right to attend upon and to prescribe for patients suffering from such venereal diseases other than syphilis, as may be prescribed, provided that the chemist follows certain regulations. The Bill gives no powers to the Commissioner to insist upon the treatment of a patient whose name and address have been sent to him as a consequence of failing to visit the medical attendant for treatment. In the other States the Commissioner possesses power to detain a suspected person, and to order a medical examination to ascertain whether the patient is suffering from venereal disease. The patient has the right to an independent examination, and a judge or magistrate must be satisfied that the patient is suffering from venereal disease. In the Bill the power of detention is not granted, but the patient has no protection against continuous treatment, unless he risks a conviction for non-attendance. The clauses dealing with prisoners undergoing imprisonment in the Victorian and other Acts are not present in this Bill, since these persons in New South Wales are already liable to the provisions of the *Prisoners Detention Act, 1908*. No powers are given to the Commissioner to order the examination of any person suspected to be suffering from venereal disease. The Bill differs from the Western Australian Act in that the clauses dealing with compulsory treatment, and its continuation, apply to all venereal disease, and not only to that in an infectious stage. In this respect the Bill follows the Victorian Act.

PNEUMONIC INFLUENZA.

We have been requested by the Consultative Council of New South Wales to publish the following document, which has been drawn up by the Chief Quarantine Officer in Sydney, dealing with the clinical types and symptoms of pneumonic influenza:—

Incubation.

From clinical experience, the incubation period varies from ten minutes to twenty-four hours. There is some evidence to show that it may extend to four days. The majority complain that they are suddenly struck down with the disease with no prodromal symptoms.

Clinical Types.

(1) Abortive.—Vague pains all over the body. It is not really a pain, but a bruised feeling from the part which is subjected to pressure from lying on the back, or across the front of the chest from the weight of the bed clothes. Headache, frontal in character, but not severe, pain down the spine. The temperature in these cases rises from 100° to 101° F., and ends by lysis and profuse sweating on the third day.

(2) Fulminating types.—The abortive type may suddenly assume a fulminating type. The patient becomes cyanosed, sometimes to a striking degree. The clinical signs of broncho-pneumonia are present. The temperature rises to 102° to 103° F. Sweating is profuse. The right heart is dilated. The dyspnoea is extreme, with frequent attacks of air hunger. The pulse remains strong, but rapid, until about an hour before the end, when it becomes soft and running. When the pulse reaches 160 and over, death has always occurred. The patients are literally overwhelmed by a toxæmia, and make no reaction whatever against the disease.

(3) Gastric type.—Bleeding from the nose and vomiting of bright red blood is common in this type of case. Others, again, have vomiting, but no hæmatemesis. Three patients passed bright red blood by the bowel, one for 52 hours, the others for 24 hours and four hours respectively. One patient had dysentery—14 motions during the day, some tinged with blood.

(4) Septicæmic form.—Patient admitted in a comatose condition, the delirium ranging from a low muttering type with carphology, to an almost delirious mania. The eyes are bright and the face has an anxious expression. Broncho-pneumonia is present or develops in the course of the disease. Towards the end, jaundice supervenes, a condition which seems to result from cloudy swelling of the liver (post mortem), and must be of a hæmolytic nature, as no obvious obstruction can be found. All cases of this type ended fatally after a protracted illness.

In only one case could the spleen be definitely said to be enlarged, although two or three complained of great pain over the splenic area. One case (P.M.) showed an abscess of the spleen.

Special Symptoms.

Pain is generalized and of a flitting nature. The patient himself cannot localize the most severe pain. Some refer it to the head (frontal) or the nape of the neck—others to the eyes and down the legs. By pressing on any part of the body pain can be localized.

The eyes.—Very few cases showed congestion of the palpebral conjunctivæ. When present it was slight in the extreme.

The nose.—Epistaxis is common. About 10% of cases exhibit coryza, the turbinates and septum showing congestion on examination.

The mouth.—The tongue is flabby, showing teeth indentations and covered with a whitish brown fur. The tongue is almost always moist. Herpes appear on the lips and sometimes on the tongue (two or three cases of broncho-pneumonia). Bleeding from the gums is rare. The soft palate is congested, and there is always a pharyngitis present.

Larynx.—Laryngitis is common. The voice is hoarse and in some cases aphonia occurs.

Trachea.—Pain along the trachea is common, and patients complain of the chest feeling "raw." The cough is irritable and dry.

The lungs.—All cases exhibit bronchial irritation, with only harsh vesicular breathing on auscultation. The cough dies away when fever declines.

Broncho-pneumonia, when present, has most usually started at the left base posteriorly as a small patch with broncho-vesicular breathing with crepitations or rhonchi (sibilant). In severe cases this patch increases in size with extraordinary rapidity, almost like an erysipelas. A patch in the morning may increase to a lobar pneumonia by night, the whole lower lobe being solid. The base of the other lobe quickly becomes affected and the lobe solid. The left lung is affected more frequently at first than the right (90% of cases). Friction rubs are common. This often leads to a collection of fluid in the pleura. Empyema develops very insidiously, and where doubt exists the needle should be used. Post mortem examinations show both lower lobes of the lungs are solid, the bronchioles stream pus, and pus has been found in the interlobar clefts. The pleura is thickened and has a dry, fibrinous appearance.

Sputum.—Ranges from a greenish yellow muco-purulent to a frothy bright red type. At first, in bad cases, a typical rusty, then bright red blood—some cases a slight hæmatemesis, then, until death, a frothy red. The sputum

in some cases is easily expectorated, in others it is of a dry, clinging nature, and has to be wiped from the mouth.

The liver.—In two cases of jaundice, liver was enlarged.

The spleen.—Slightly enlarged (post mortem results).

Kidneys.—Urine dark in colour, high specific gravity and a heavy cloud of albumin. Retention of urine is common. Kidneys (post mortem) acute cloudy swelling.

Heart.—The toxin has a disastrous result on the heart muscle. The pulse is at first slow and has no relation to the temperature. The tension and volume are good. Later, in fatal cases, the right heart becomes dilated, a soft murmur is heard in the tricuspid area and the pulse assumes a running type, its rate going up to 160-180. Cyanosis may be extreme.

Ears.—Four cases of deafness developed in course of the disease. All patients have recovered.

Brain.—All patients are heavy and stupid on admittance and remain like that until defervescence takes place. The delirium in bad cases may be very severe and distressing to witness.

Convalescence.

The lassitude is extreme even in mild cases. Relapse is common. The pulse-rate is slow, 40-60 per minute. Dyspnoea on exertion is common. The heart muscle is liable to be seriously involved. Frontal sinuses have developed in two cases.

December 4, 1918.

Report of an Ordinary Case of Pneumonic Influenza.

W.D., aet. 17, male, S. S. Medic, admitted November 21, 1918.

Patient became ill seven days ago. He had pain in both sides. The pain was radiating in character, and was severe when the side was subjected to pressure, such as lying on it. He has had continuous severe frontal headache. Last night his nose bled a good deal. To-day he has vomited bright red blood. He had cough, with scanty expectoration. The temperature on examination is 100°, the pulse-rate 76, and the respiration 32. The tongue is flabby, moist and covered thickly with a white brownish fur. The soft palate and posterior pharyngeal wall are congested. There is no abdominal pain on palpation. Liver dullness is not increased. Spleen is palpable.

Lungs.—Inspection: No restriction of movement. Palpation: vocal fremitus slightly increased at the left base posteriorly. Auscultation: breathing harsh vesicular over both bases. At the left base anteriorly there is harsh vesicular breathing, with sonorous rhonchi. Breathing at left base posteriorly broncho-vesicular, with crepitations at end of expiration. Percussion: left side very slightly duller than at the right base. The vocal resonance is increased at the left base.

Heart.—No increased dullness; sounds normal.

Urine.—1,025 acid, albumin, slight cloud, no sugar.

November 23, 1918.—Temperature 101°, respiration 26. He is complaining of pain in the left axilla. Percussion, dullness at left base and axilla. Breathing, bronchial with crepitations; vocal resonance increased. Friction rub pronounced in the left axilla. He is looking very toxic to-day.

November 24, 1918.—Temperature 99°; he has now broncho-vesicular breathing at the right base, with crepitations.

November 25, 1918.—Temperature normal. He is sweating profusely.

November 26, 1918.—He vomited all last night. The vomitus is streaked with blood. The temperature is 101°. The tongue is still moist and heavily furred. Both bases are dull, with pure bronchial breathing and crepitations. He still has pain in the left axilla and over the spleen. The bowels are well open and normal.

November 27, 1918.—The condition is the same. He is very cyanotic and toxic to-day. Pain in the axilla is not so severe. The tongue is still very dirty.

November 28, 1918.—Pain is still very bad over the spleen. Consolidation of the bases has not increased in extent. His colour has improved. The temperature is 102°. He has pain in the abdomen, due to coughing, and is still vomiting.

November 29, 1918.—The temperature is 102°. He has pain in the left side. His bowels are well open. The tongue is still dirty. Lungs, dullness at both bases, with bronchial breathing and loud râles palpable by the hand. His spleen is still enlarged. The tongue is very dirty.

November 30, 1918.—His colour is normal, and the temperature is normal. The tongue is still dirty. Chest, loud râles are present, and the patient is expectorating large quantities of muco-purulent sputum.

December 1, 1918.—He has still further improved. The temperature is normal and the tongue cleaning. Urine 1,018; no albumin, no sugar.

December 2, 1918.—The tongue is clean and the temperature normal.

December 3, 1918.—The patient is convalescent.

December 4, 1918.—He is not coughing so much. The temperature remains normal.

Diagnosis.—A gastric type complicated by broncho-pneumonia.

Sputum.—At first muco-purulent, then rusty, then bright red in colour, then rusty and, finally, muco-purulent.

Naval and Military.

CASUALTIES.

In the 450th list of casualties sustained by Australian troops on active war service, there appears the name of Captain Charles Roy Lister among those who have "died of other causes." The death of Captain Lister was announced in the columns of *The Medical Journal of Australia* of December 7, 1918. In addition, the list of those ill contains the following names of medical officers:—Major Kenneth Stuart Cross, Captain William Edward Blackall, Captain Thomas Ross Jagger, Captain Ferguson Frederick Augustus Lemon, Captain Eric Henry Lewis and Captain Francis Richard Meagher.

HONOURS.

The Military Cross has been awarded to the following medical officers of the Australian Army Medical Corps:—

Captain L. W. Hunter (? L. J. Hunter).

Captain Thomas Ross Jagger.

Captain Sydney Michael O'Riordan.

Captain Francis Louis Trinca.

Captain Frank Elliot Trenoweth True.

Captain Paul Ernest Voss.

APPOINTMENTS.

The following appointments, etc., have been notified in the *Commonwealth of Australia Gazette*, No. 188, of December 5, 1918:—

Citizen Naval Forces of the Commonwealth.

Royal Australian Naval Brigade.

The resignation of Arthur Adrian McKay of his appointment of Surgeon and as Sub-District Naval Medical Officer at Maryborough (Queensland), to be accepted, dated 31st May, 1918.

Australian Imperial Force.

Appointments terminated.

Second Military District.

Lieutenant-Colonel C. E. Wassell, D.S.O. Dated 13th

November, 1918.

Captain J. G. Hunter. Dated 4th October, 1918.

Captain C. J. Taylor. Dated 23rd October, 1918.

Third Military District.

Captain V. G. Webb. Dated 28th September, 1918.

Fourth Military District.

Major K. N. Steele. Dated 18th November, 1918.

We regret to announce the death of Dr. Henry Guy Seymour Warren, of Sydney, New South Wales.

Abstracts from Current Medical Literature.

SURGERY.

(204) Rupture of the Excluded Bowel.

Rutherford Morison (*Brit. Journ. Surg.*, July, 1918) records a case of intestinal obstruction in which there were present two malignant strictures. At the time a lateral anastomosis only was performed, owing to the patient's condition, and during the three weeks which elapsed before the patient's condition was sufficiently good to justify further intervention the patient nearly died of rupture of the portion of the bowel between the two strictures. He therefore reiterates his previous statements of the danger of occluding portions of the bowel. He points to the experimental work of Drummond, who isolated a loop of bowel and after performing an anastomosis between the cut ends returned the isolated loop, with open ends, into the abdomen. The patients recovered, whereas those in whom the ends of the excluded portion were sutured invariably died some days after operation. In these cases either a gangrenous or a perforated condition of the occluded bowel is revealed post mortem. Morrison maintains that the bursting of the intestine begins by the formation of a rounded or oval gangrenous patch, and claims that tension gangrene is much more common than bacterial gangrene.

(205) Restoration of Circulation After Ligation of Main Trunks.

The question: How does a limb behave after ligation of its main trunks? is discussed by Derache and Voncken (*Bull. et Mém. de Soc. de Chir.*, Paris, July, 1918). The limb is not necessarily condemned to gangrene. Indeed, the simultaneous ligation of the vein and artery favours the nutrition of the limb and lessens the risk of ischaemia. Makins has recently recommended ligation of the vein also in cases where the artery alone has been injured. Venous arborization following this procedure becomes marked, especially near the root of the limb. The limb itself remains slightly colder than its mate, but still retains a sufficient temperature. Motility is not completely abolished, and is manifested especially on the flexor side. The blood pressure of the affected limb is the most interesting of all the signs. Using the oscillogram of Pachon, it is found that, immediately after ligation, the blood pressure below the ligation is nil. After remaining nil for three or four days, feeble oscillations appear, and these progressively increase. Towards the end of the second week there exists a difference between the systolic and diastolic pressures of six to ten centimetres of mercury. This stage remains stationary and seems to represent the maximum that compensation can give.

(206) Shell Wound in the Heart.

Mocquot reports a case of shell wound of the heart (*Bull. et Mém. de Soc. de Chir.*, July, 1918). The patient was admitted to a field ambulance in a collapsed state, with uncountable pulse and a shell wound of the right breast. Fourteen hours later he showed left-sided hemiplegia. His respirations were so noisy as to mask all auscultatory signs. X-ray examination revealed a large piece of shell at the level of the fourth costal cartilage, about 8 cm. deep and half way between the mid-line and left nipple line. Under ether the thorax was entered through a trap-door incision, but no hemothorax was discovered. Exploration of the pericardium revealed nothing, and incision of it showed no hemo-pericardium. There was no apparent wound of the heart, although on squeezing the left ventricle the sensation of a foreign body was felt. The cyanosis increased so much that nothing further was done. The patient sustained the operation well, and his pulse was only 120 at its conclusion, but he died rather suddenly a few hours later. Post-mortem an irregular, furrowed wound was discovered in the right auriculo-ventricular groove and a piece of shell was found lodged between the valves of the mitral orifice in the left ventricle. The interesting points are the relatively long survival—20 hours—after so grave a lesion, and the absence of any hemorrhage. The hemiplegia was evidently due to emboli.

(207) Gun-Shot Wounds of the Lung.

Eggers (*Surg., Gynec. and Obstet.*, June, 1918) discusses the treatment of gun-shot wounds of the lung. These are said to account for 40% of all deaths, and Sauerbrück, examining 300 dead on the battlefield, found that lung wounds accounted for 30%. He favours the conservative treatment of perforating wounds of the chest. If hemothorax produces symptoms of compression he aspirates, but if possible aspiration is avoided during the first ten days, owing to the danger of secondary hemorrhage. An infected hemothorax is aspirated at first, and, if this is not sufficient, later a rib is resected and the empyema drained. An open pneumothorax, with small external opening, should be closed by suture if the wound is clean or by a firm tampon in case of doubt. In an open pneumothorax with large external opening the wound edges should be excised and the lung itself stitched to the edges of the opening. Eggers prefers doing such operations under intratracheal anaesthesia, using a simple positive pressure pump, such as that recommended by Fischer.

(208) War Surgery of the Spinal Cord.

Frazier, reviewing the subject of war surgery of the spinal cord (*Surg., Gynec. and Obstet.*, June, 1918) follows Gordon Holmes' classification of cord lesions: (1) complete, with flaccid paralysis; (2) partial, with spinal hemiplegia or the Brown-Séquard syndrome; (3) lesions of compression, with spastic paraplegia and increased reflexes; (4) lesions of the cauda equina. He emphasizes

the importance in diagnosis of examining the muscles of the trunk, e.g., in lesions of the ninth thoracic segment the lower part of the rectus is paralysed, while the upper part contracts vigorously. The condition of the intercostals is likewise of importance. Symptoms of disturbance of the cervical sympathetic may be obtained in lesions between the second cervical and second thoracic segments. X-rays are valuable, but fractures of the spinous processes are not easily detected, and even stereoscopically it is difficult to determine whether a bullet lies within or without the canal. Treatment is a complex problem. In indirect lesions the symptoms may be those of a complete transverse lesion, and in these cases it is better to wait, reserving intervention for any persistence without improvement of the condition. In direct injury, on the other hand, Oppenheim holds laminectomy justifiable, even in the presence of an apparently complete transverse lesion, since there is nothing to lose by operation. Some surgeons advise operation immediately after recovery from shock, while others wait five weeks. As to whether the *dura mater* should be closed, opinions again differ, but the splendid barrier provided by the *dura* against sepsis is an argument for its closure, except where this might result in compression of an edematous cord. To avoid bladder infection supra-public cystotomy should be performed, or the bladder allowed to empty by overflow.

(209) Acute Diverticulitis of the Colon.

In a communication to *Surg. Gynec. and Obstet.*, February, 1918, J. Ferdmann reviews 26 cases of acute diverticulitis of the colon. The condition is apparently more common in males, and frequently occurs in well preserved subjects. Tenderness in the hypogastrium and in the left lower quadrant is the main symptom. Constipation is usually present, but there is no blood or mucus in the faeces. Occasionally, acute attacks resembling acute appendicitis occur, but the pain is not in the right lower quadrant. In 25 operations there were three deaths, one from sepsis in a gangrenous case; another from sepsis following resection; and the third from obstruction following resection. Post operative fistula followed in four cases. The differential diagnosis has to be made from appendicitis and carcinoma. In the latter, the history of constipation alternating with diarrhoea, and the presence of blood and mucus may be of diagnostic value, while sigmoidoscopic examination will reveal a lesion within 30 to 40 cm. of the anus. The condition may terminate acutely in abscess, perforation or gangrene, like an acute appendicitis. It may become subacute, like a "growling" appendicitis, or it may become chronic with obstructive symptoms. Carcinoma may be a late complication. The operative treatment in the acute cases consists in drainage with or without excision and suturing. In the chronic cases resection with end-to-end anastomosis is necessary.

GYNÆCOLOGY AND OBSTETRICS.

(210) Spinal Analgesia in Gynæcology.

Naguib Mahfouz Bey gives an account of 1,552 consecutive gynæcological cases operated upon under stovaine at the Kasr-el-Ainy Hospital, Cairo (*Lancet*, August 3, 1918). Technique: An all-glass 3 c.cm. syringe is used, with needles of steel and of medium length and fine calibre. For abdominal operations the puncture is made in the third lumbar space, and in rare cases the second. For dilatation of the cervix the third space, and for vaginal and perineal operations the fourth. The operations performed were mainly gynæcological; only 37 were obstetrical. All the routine gynæcological operations were performed, and included the removal of ovarian cysts or myomata up to 38 lbs. in weight. The duration of analgesia was sufficient for operations lasting less than 90 minutes. Wertheim's operation for cancer of the cervix required a little chloroform to finish the operation. Analgesia failed to appear in 1.28% of cases, and was not sufficiently prolonged in 0.90%. There were no deaths from stovaine. Perineal sensation was abolished immediately after the injection. In from three to ten minutes analgesia would have extended to the umbilicus or the ensiform cartilage, according as the injections were made in the fourth or the third lumbar space. Nausea and transient vomiting accompanied the analgesia in 2% and 3% of cases respectively. Signs of depression rarely occurred and seldom caused anxiety. The post-operative symptoms were limited to headache, which was easily amenable to treatment and occurred in 1% of cases. Vomiting and paralytic conditions were entirely absent. The solution used in the later cases consisted of *sod. chlor.* 0.0022, stovaine 0.08, water to 2.00. It has been found best to use the same dose in all cases, as the analgesia passes off quickly with a smaller dose. The author states that stovaine is far superior to chloroform for all gynæcological operations. During abdominal operations the complete relaxation of the abdominal muscles and the evenness of the analgesia are a great help to the operator. The freedom from rhonchi and respiratory troubles are points in favour of stovaine.

(211) Extending the Care of Pregnancy.

Ira L. Hill (*Journ. Amer. Med. Assoc.*, September 14, 1918) states that little has been added to what has been known for years about the care of pregnancy. For 29 years the death-rate from childbirth for women in America has not decreased, but this rate could be decreased if all the available means were used in every case. Regulation of midwives has produced very good results. The death-rate is less in cases where only midwives are in attendance. The gains from prenatal care are illustrated by figures given by the Committee for the Reduction of Infant Mortality in New York. Among 3,000 women closely supervised during pregnancy there was a

decrease in maternal mortality of 69%, 28% decrease in deaths of infants under one month, and 22% decrease in stillbirths. Dr. J. Whitridge Williams has prepared the following as a standard of medical pre-natal care: (1) A general physical examination, including an examination of the heart, lungs and abdomen. (2) Movements of the pelvis in a first pregnancy, to determine whether there is any deformity which is likely to interfere with birth. (3) Continued supervision by the practitioner at least through the last five months of pregnancy. (4) Monthly examinations of the urine at least during the last five months. The Maternity Service Association of New York also specify a blood pressure estimation at each visit and a Wassermann test in suspicious cases. The author states that the problem is a national one, as over 15,000 women die annually in the United States from childbirth, and that the State should provide for the supervision of pregnancy. The author considers that the doctor should be paid for the extra work involved.

(212) Fibroid Tumours Treated by Radium.

Howard A. Kelly (*Surg., Gynec. and Obstet.*, October, 1918) mentions the danger and untoward sequelæ of hysterectomy for fibroids, even in skilled hands, and states that he had operated upon about 2,000 women for fibroids before he became convinced that treatment by radium was a safer and better course. He presents a list of all patients he and Curtis F. Burnam have treated with radium during the last five years. They claim the following results: (1) Control of hæmorrhage and the checking of menstruation. (2) The shrinkage of the tumours. (3) In many instances the disappearance of the tumours. (4) In some instances (even after two years) the return of menstruation, either normal or scanty. The mortality was nil, and 21 of the cases had serious systemic disease. Of their patients, 146 were 40 years and over and 64 were under 40 years. During the five years 45 cases were treated by operation; these were usually complicated by the presence of some other condition. If there is doubt about the diagnosis, operation is to be preferred. The author analyses the two groups. Group I, patients of 40 years and over. Of the 146 patients, 16 are set aside as the data are insufficient and two died from other causes. In the 128 remaining 123 show disappearance or marked diminution of the tumour, with cessation of symptoms. The most obvious result of radiation is its effect on menstruation. Twenty-eight women did not menstruate after treatment, 48 menstruated once and 31 menstruated twice or more before amenorrhœa was established. In ten cases bleeding did not cease and treatment had to be repeated several months later to secure amenorrhœa. Group II, 64 patients under 40 years of age. In these cases menstruation sometimes returns after a year or more. In 23 the tumour has disappeared and in 16 the tumour has decreased in size. Taking the two

groups together, 28 cases have insufficient data; 182 cases remain, and all but 11 patients were relieved by radium. In five of the eleven there was some complicating condition. One proved utterly resistant to several treatments. Where menstruation is not stopped by the treatment, or where menstruation returns before the fibroid is gone, the tumour is likely to continue to grow. Further treatment will stop menstruation and check growth. Technique: A careful general and local examination is necessary in each case. A preliminary curettage is done, to rule out malignancy and remove any polyp. Polypoid tumours obstructing the cervix are removed vaginally. Calcified fibroids are diagnosed by X-ray examination. The radium affects the cells of the fibroid more than the ovarian cells, but amenorrhœa is aimed at, and is an excellent guide to adequate dosage. As a rule, a single intra-uterine dose of 1,500 millicurie hours is sufficient to produce an amenorrhœa, with shrinkage or complete disappearance of the tumour. An equal effect may be produced by radiation with a gramme of radium distributed at various points over the tumour for 24 hours. The external and internal treatments may be combined, but the internal application should not exceed the 1,500 millicurie hours or local injuries may be caused. In the internal application the position of the radium is altered every half hour, the patient being left in the same position during the three hours of the treatment by means of pillows and sandbags. In the external treatment four or five grammes of radium are used for five or six hours. At least seven weeks should pass before repeating the treatment, and it should be omitted if amenorrhœa is already secured. Some fibroids show marked decrease in a month or two, others disappear gradually within a year. Treatments should be given at intervals of three or four months, to maintain the amenorrhœa.

(213) Exfoliative Vaginitis.

William Kerwin records two cases of exfoliative vaginitis, in which no ascertainable cause for the separation of casts of the vaginal mucosa could be discovered (*Surg., Gynec. and Obstet.*, August, 1918). In one case no less than forty complete casts of the vagina were passed at intervals of one to three weeks from September, 1911, to September, 1912. Sexual intercourse, douches, excitement and similar possible causes were absent. The second patient passed three casts within two months. The vagina, after the expulsion of the casts, had a reddened appearance, but was otherwise natural. It has been suggested by some authorities that this rare condition is of nervous origin, while its association with exfoliative endometritis has been noted. The majority of the cases recorded have been due to some chemical or thermic irritant, such as phenol or chloride of zinc, or very hot douches. The histological characters of the casts are described and a short summary of the literature is appended.

British Medical Association News.

ANNUAL MEETING.

The Annual Meeting of the Victorian Branch, and simultaneously of the Medical Society of Victoria, was held at the Medical Society Hall, East Melbourne, on December 4, 1918; Professor R. J. A. Berry, the President, in the chair.

Election of Office-Bearers.

The result of the election of the office-bearers and members of the Council of the Victorian Branch and of the Committee of the Medical Society of Victoria was announced as follows:—

President: Dr. J. Ramsay Webb (unopposed).

Vice-Presidents: Drs. L. J. Balfour and Basil Kilvington (unopposed).

Honorary Secretary: Dr. J. W. Dunbar Hooper (unopposed).

Honorary Treasurer: Dr. C. H. Mollison (unopposed).

Honorary Librarians: Drs. Allen Robertson and H. Douglas Stephens (unopposed).

Members of the Council and of the Committee: Drs. A. V. M. Anderson, S. Argyle, W. R. Boyd, C. Crellin, F. L. Davies, J. R. Davis, R. H. J. Fetherston, T. E. L. Lambert, A. N. McArthur, J. N. Morris, D. Rosenberg, W. H. Summons, J. F. Wilkinson and A. J. Wood.

Annual Report.

The Annual Report of the Council was presented and adopted.

Annual Report of the Council for Year Ending December 4, 1918.

The Council of the Branch and the Committee of the Society present the Annual Report for the year 1918:—

Election.

At the Annual Meeting held last December the following office-bearers and members of the Council and of the Committee were elected:—

President, Professor R. J. A. Berry; **Vice-Presidents,** Drs. L. J. Balfour and Basil Kilvington; **Honorary Treasurer,** Dr. C. H. Mollison; **Honorary Secretary,** Dr. J. W. Dunbar Hooper; **Honorary Librarians,** Drs. Allen Robertson and H. Douglas Stephens.

Members of the Council and of the Committee.—Drs. A. V. M. Anderson, W. R. Boyd, B. Crellin, F. L. Davies, J. R. Davis, T. P. Dunhill, R. H. Fetherston, A. Norman McArthur, D. Rosenberg, J. Ramsay Webb, J. F. Wilkinson and A. Jeffreys Wood.

At a subsequent meeting of the Council the following appointments were made:—

Members of Council, Drs. W. Ernest Jones and R. L. McAdam; **Honorary Assistant Secretary,** Dr. J. Newman Morris; **Honorary Assistant Treasurer,** Dr. Alex. Lewers.

Council Meetings.

There were 22 Ordinary Meetings of the Council and 16 Special Meetings, at which the attendances were as follow:—

Dr. Davies 38	Dr. Jones 23
" Robertson .. 38	" McArthur† .. 23
" Rosenberg .. 38	" Lewers .. 18
" Hooper .. 37	" Webb* .. 19
" Balfour .. 35	" Wood .. 18
" Boyd .. 35	" Stephens .. 18
" Morris .. 35	" Anderson* .. 15
" Crellin .. 32	" Fetherston* .. 11
" Davis .. 30	" Hughes* .. 3
" Wilkinson .. 27	" Dunhill* .. 0
" Berry† .. 27	" McAdam† .. 0
" Kilvington .. 25	

Trustees—	
Dr. Mollison .. 23	Sir Harry Allen .. 1
" Syme .. 25	Dr. C. S. Ryan* .. 0

Country Divisions—	
Dr. Spring (Ballarat) 21	Dr. Jacobs (Bendigo) .. 1
" Kennedy (Geelong) .. 18	" MacGowan (Ballarat) .. 1
" Bonnin (Wimmera) .. 2	" Moreton (Geelong) .. 2
" Frost (Bendigo) 2	

Dr. Sloss (Ballarat) 2	Dr. Florance (Goulburn) 0
" Green (Bendigo) 1	
" Henderson (Bor-der) 1	

Sub-Committee.

The following Sub-Committees were appointed by the Council, the first-named members acting as Conveners. The President and Honorary Secretary are *ex officio* members of all Sub-Committees:—

Organization.—Drs. Allen Robertson, Anderson, Boyd, Wilkinson, Davis, Rosenberg, McAdam, Crellin, Balfour, Fetherston, McArthur, Kilvington, Morris and all the Secretaries of Divisions.

War Organization.—Mr. Crouch, Drs. Boyd, McAdam, Dunhill, Wood.

Press.—Drs. Lewers and Wilkinson.

Ethical.—Drs. Anderson, Kilvington, Lewers, McAdam, Davies and Balfour.

Legislative.—Drs. Crellin, Davies, Jones, Morris.

House.—Dr. Mollison.

Scientific.—Drs. Lewers, Stephens, Robertson, Kilvington, Hiller, with power to add.

Medical Agency.—Drs. Hughes, Mollison, Robertson, Crellin and Kilvington.

The following appointments were made by the Council:—

Bush Nursing Association.—Dr. Stephens.

Advisory Board to Medical Inspectors of Schools.—Dr. Stephens.

Free Kindergarten Union.—Dr. Stephens.

Representative on the Representative Body.—Dr. Maudsley.

Representative on the Central Council.—Dr. Newland.

Representative on Federal Committee.—Drs. Fetherston and Syme.

Victorian Correspondent for British Medical Journal.—Professor Berry.

Representative on Venereal Diseases Advisory Council.—Dr. Mollison.

Membership Roll.

The number of members on the roll is 930, as against 917 of the preceding year. During the year there has been a gain of 52 members (32 by election, 8 paid arrears, and 12 by transfer from other States). On the other hand, 39 have been lost (13 by transfer, 2 by resignation, 3 by expulsion, 15 by death and 6 whose subscriptions have been allowed to fall 2 years in arrears).

With regret there have to be recorded the deaths of the following members: Drs. J. D. Boyd, F. J. Keyes, A. G. Jackson, Jas. Buick, W. S. Garnet, R. B. Duncan, J. P. Ryan, W. H. Burton, H. H. I. Ingham, D. Skinner, D. D. Jamieson, F. E. Dunkley, A. R. Fox, G. F. Wickens and C. Alwyn Stewart.

War.

Of 930 members of the Association 351 enlisted for whole-time military service, and of these 128 have returned and 223 are now abroad. With the return of these members it devolves upon the Association to see that their practices shall be, as far as possible, restored unimpaired, together with any appointments involved.

A large measure of generosity should also be extended to those members of the A.A.M.C. who proceeded direct from the University to active service abroad.

Since the last report the following members have died on military service, and letters of sympathy have been extended to their relatives: Drs. A. R. Fox, D. D. Jamieson, C. J. Oliver, P. B. Sewell, C. Alwyn Stewart, while two other Melbourne graduates have also died in the cause—Drs. Johnston Hughston and A. H. O'Hara Wood. This makes a total of 34 Victorian medical practitioners who have died for their country.

The Council unanimously decided to cordially support the Medical Officers' Relief Fund, which was brought before the Federal Committee and referred to the Branches for consideration. The object of the fund is to assist medical officers who have been disabled, and the dependants of those who have died. It is proposed that loans shall be issued from the fund, with or without interest, to medical men who, on account of war service, may require temporary financial assistance.

* On military service. † Absent through illness. ‡ Absent from State.

Your Branch has appointed as local trustees Lieutenant-Colonel J. Ramsay Webb and the Honorary Treasurer and Honorary Secretary B.M.A. This fund is now open for donations from members of the profession, and it is earnestly hoped that a most generous support will be accorded to it.

Dispute with the Friendly Societies.

This matter has received the constant and careful attention of the Council. It has been the subject matter of debate at all but one special meeting and at most of the ordinary Council meetings. Throughout the year the brunt of the work has fallen upon the Organization Committee, which has held over 120 meetings. The matter may be most conveniently dealt with under five headings:—

- (1) The course of events since this date last year.
- (2) Our success in keeping members united.
- (3) The failure of the friendly societies to check our determination to control the conditions of lodge medical practice.
- (4) The failure of the friendly societies' efforts in the last three months seriously to extend medical institutes, and
- (5) The policy of the Council as to the future relations with friendly societies.

1. A series of negotiations has taken place within the past twelve months. The heads of various Governments of the State announced in turn that they were going to settle this dispute, and innumerable conferences have taken place before Messrs. Bowser and Lawson. Extraordinary threats were used to persuade your delegates to withdraw from the position they had taken up. Your Council declined to submit to arbitration in any form, as it held that the remuneration demanded was a concession to the wage-earning people, and it was the medical men's right to say how far and to whom this concession should extend. The Council consistently took up this stand—that it would submit to no form of arbitration.

Mr. Lawson proposed that a conference should be held under the chairmanship of a judge. To this proposition your Council readily consented, though there was little hope of any successful results. The chairman, His Honour Judge Moule, had received instructions from the Crown Law Department which were entirely misleading, and in opening the proceedings he stated that he hoped, under his guidance, the delegates would be able to arrive at an agreement on most points, and that he would decide on any points in which agreement could not be reached. He thereupon produced a document already prepared, which he desired the delegates to sign, undertaking to be bound by his decision. He was informed that he had mistaken the position, and that the B.M.A. had only consented to take part in the conference on the understanding that he was to act as a friendly chairman, in endeavouring to bring about agreement between the delegates of either side, and that the B.M.A. has not prepared to submit to arbitration in any form.

The conference proceeded and the chairman very soon arbitrated on the subject of remuneration. We intimated at once that our delegates could not take any further part in the proceedings. Then came a Bill for arbitration. Delegates were to be appointed from either side, and a judge of the Supreme Court was to sit as arbitrator. The Council of the B.M.A. refused to appoint delegates, and the Bill was not enforced. Next a Royal Commission was appointed by the Cabinet to inquire into the dispute and arrange a settlement. After conferring with legal counsel, it was decided to appear, and to be represented by counsel. At the opening of the proceedings the Commissioner was informed that we appear as loyal subjects of the King, to assist the Commission in the inquiry for which it was appointed, and counsel informed the Commissioner that unless the report was acceptable, our Association did not undertake to be bound by it.

After three weeks of inquiry, Judge Wasley issued a report, which was a complete vindication of the claims of the Association. We accepted the terms of the Commissioner's report, with one condition—that new institutes formed to defeat the demands of our members—demands which the Commission declared to be in substance reasonable and just—should be abolished. The friendly societies declared that they could not accept the terms, and said,—

- (1) That their right to establish and conduct institutes was their constitutional birthright.

- (2) They had incurred such a liability with medical men that it was impossible to abolish these institutes without vast expense (variously computed between fifty and sixty thousand pounds for compensation).

Again the Premier approached the Council, and made appeals to induce it to withdraw the condition. It was then suggested that the good offices of counsel who had appeared before the Royal Commission might be sought, and to this the Council assented. Negotiations by counsel on either side were conducted very earnestly—Mr. McArthur, K.C., Mr. Dixon and Mr. Lowe gave much time and thought in their endeavour to bring about agreement, and did so as a public duty, without any fee or reward. The efforts of counsel were undertaken on condition that the proceedings were to be without prejudice and confidential. They finally reported to the Premier that they regretted they were unable to bring about an agreement.

Your delegates recognized the friendly societies' difficulties, and at this conference counsel for the British Medical Association put forward as a final effort the following conditions, under which medical institutes might be allowed to remain:—

- (1) No institutes to be established for five years.
- (2) No re-appointment nor any additions to the medical staffs to take place for five years.
- (3) No filling up of vacancies for five years (this provides for terminating the institutes at the time contracted for).
- (4) Members of friendly societies to pay the Wasley rates, whether on the lists of British Medical members or medical institute medical men.
- (5) Re-appointment of all British Medical Association members to lodges.
- (6) Every member of a friendly society to have the choice of having his name placed on B.M.A. or institute list.

2. As to the measure of success we have had in keeping members together, only three have accepted institute appointments. These three have been expelled from membership of the Association. Only one man has gone back on his word and intimated that, contrary to the directions of the Council, he was willing to sign forms of agreement on the Wasley rates. His conduct had been in doubt for some time, and he was summoned to appear before the Organization Committee, to answer the charge, but failed to keep his two appointments and intimated that he intended to act as stated above, and he informed his lodges that on the 1st September he was ready to sign the agreement.

At the Council meeting his expulsion was carried unanimously, and the expulsion has been confirmed at the last general meeting of the Association. With this exception, so far as we know, there has been a unanimous and loyal observance of the directions of the Council. We have had reports impugning members of not playing the game, but these on investigation in nearly every case have had little or no foundation, and in every case reported there has been no serious interference with the progress of the campaign.

3. Letters have been received from members, that lodges in their district were willing to grant Wasley terms, and that as they—the members—were willing to accept such terms, they did not see any reason why they should not be allowed to do so. The reply given was that the only reason they have been offered Wasley terms is because of the united effort of our members; if it had not been for this united effort they would not have been offered the terms of the Commission, and acceptance of the terms would be a breach of faith on all other members who were working for the common good, and who were not offered an opportunity of accepting similar terms. Reports received from our members say that they are doing as well as, and in many cases better than, before the resignations were sent in. In towns where institutes have been established some few men had suffered financially, and the Organization Committee has provided material assistance in a few cases.

4. Within the last five months there has been a failure on the part of the friendly societies to extend their medical institutes. There has been no increase in the number of appointments. At Geelong there are three—Drs. Barnard, Campbell and Walker. At Williamstown three—Drs. Boughton, Craig and Sleeman; at Prahran, Dr. Bretherton is an additional one; Clifton Hill, Dr. Carnegie; South Melbourne,

Drs. Finnis, Potts and Greenwood; Brunswick, no alteration; Ballarat, Drs. Holmes, Sturgess and Romeo; Dr. Kelmar was appointed and dismissed; Maryborough, Dr. McCutcheon; Port Macquarie, Drs. O'Dwyer and Leary (who has been dismissed); Ararat, Dr. Parker; Brighton, Dr. Parkinson; Hawthorn, Dr. Roche; Richmond, Dr. Simpson; Malvern, Dr. Weir; Carlton, Dr. Godfrey; Footscray, Dr. Egland.

The friendly societies are at their wits' end to make both ends meet; and those lodges which at the outset expressed their willingness to meet the doctors' bills, are now only paying a proportion and in some cases nothing at all. It is believed that such payments will be in an ever-diminishing quantity.

5. The policy of the Council as to its future relations with the friendly societies is:—

- (1) Steadfastly to maintain its objection to the permanent establishment of the new medical institutes.
- (2) To decline to sanction any appointment of its members to any lodge of any Order, which continues to support such institutes.
- (3) To delay the establishment of any form of Direct Medical Contract controlled by the B.M.A., until such time as the friendly societies have had further opportunity of considering the position.

Ethical.

Many matters have come before the Ethical Committee for consideration. Notices appearing in the personal columns of the lay press, with regard to attendance upon prominent citizens, have not been so much in evidence as in former years. The matter of advertising in the country press has been before the Committee on several occasions, and gradually the practice is being checked.

The recommendation that homœopathic practitioners should be admitted to membership of the Association was adopted by the Council, subject to the approval of the Federal Committee. In the discussion before this Committee it was evident that the motion would be lost, so the matter was withdrawn.

The Committee laid down general principles which should govern holiday practice, so that the interests of the resident practitioners at holiday resorts might be conserved as far as possible. A copy of these principles as adopted by the Council was forwarded to each member.

The question of the amount of charge for medical certificates required by insurance companies was considered and by the Council referred to a general meeting of members. The Federal Committee had asked each Branch to adopt one guinea as the minimum charge for all such certificates, and, in reply to some few members of the Branch, the Council had intimated such determination. However, the Branch has now laid it down that for the short form of certificate, one not requiring an examination of urine, etc., the minimum charge should be half-a-guinea.

A large number of ethical questions between member and member were referred to the Ethical Committee and adjudicated upon.

Legislation.

The Medical Act has been amended so as to make it compulsory for every medical man to affix his signature, address and date to all prescriptions. In this connexion members returning from abroad are advised that they are compelled to report every case of venereal disease under their care.

A Bill passed the Legislative Assembly for the abolition of compulsory vaccination. Your Council issued a protest to each member of the Legislative Council, pointing out the efficacy of vaccination as a prophylactic and the danger the public would incur should the provisions of the Act be relaxed. Since this was written the Bill has been rejected by the Legislative Council.

Under the *Midwives Board Act* regulations were framed which the Council believed tended to work to the detriment of the medical profession. A conference was held with the authorities administering the Act, and satisfactory assurances were given.

A sub-committee is now engaged drawing up a pronouncement as to the limits within which nationalization of the profession is regarded as tending to the welfare of the public. The whole matter is to be referred to the Federal Committee, which meets in Melbourne next February.

Public Hospitals.

The question of treatment of well-to-do patients in public hospitals has again been before the Council. At the request of the Inspector of Charities, a special meeting of the Council was called, to consider a scheme drawn up by himself, with the concurrence and approval of the State Treasurer, for the establishment of intermediate hospitals. He admitted that without the full support of the B.M.A. any scheme would be a failure. The Council reaffirmed the decision of Congresses, and of the Federal Committee on two occasions, that public hospitals should be reserved exclusively for the sick poor.

Medical Agency.

The Medical Agency, conducted by the Medical Society of Victoria, has more than justified its existence. A large amount of business has been transacted, and satisfaction has been expressed by clients. The Council of the B.M.A., through the agency of the Medical Society, is now in a position to place medical practitioners returning from active service abroad in places best suited to their requirements. The Agency is at all times ready to give advice to such men in all matters touching the position of affairs in Victoria and other States. The balance-sheet will be published in February next, together with those of the B.M.A. and Medical Society of Victoria.

Rules of the Association.

A Sub-Committee has been asked to revise the Rules of the Association governing the constitution of the Council, and also with regard to the more complete representation of sub-divisions on that body. These matters will have the immediate attention of the incoming Council.

New B.M.A. Buildings.

But for the protracted negotiations with the friendly societies, this subject would have had a more prominent place in the deliberations of the Council. The present buildings are inconveniently situated, dilapidated, and ill-suited to the requirements of members, library and staff. A more central position would be conducive to a larger attendance at the meetings, and a greater interest in the affairs of the Association.

A Sub-Committee of your Council met delegates of the Royal Society of Victoria, with a view to mutual co-operation in erecting new and suitable buildings on the present Royal Society or other site. Consideration of this proposal has been deferred for the present.

Monthly Meetings.

Seven monthly meetings were held and two clinical meetings. A further meeting was held in conjunction with the Odontological Society. The following papers were read:—

Dr. H. Douglas Stephens.—"Poliomyelitis—the Present Epidemic."

Colonel J. Ramsay Webb.—"Work at a Casualty Clearing Station."

Major W. Kent Hughes.—"Experiences in Russia."

Lieutenant-Colonel E. R. White.—"War Experiences in Gallipoli and Palestine."

Dr. T. E. L. Lambert.—"Spinal Bone Grafting."

Dr. T. Garnet Leary.—"Stammering and Stuttering with Corrective Measures."

Dr. C. G. Godfrey.—"Stammering Treated by Hypnotism."

Dr. Leonard Mitchell.—"Eye and Ear Work on Active Service."

Dr. J. M. Lewis (Odontological Society).—"Pyorrhœa Alveolaris."

On behalf of the Council,

C. STANTON CROUCH, Secretary.

Librarians' Report.

The Library is now in receipt of 73 journals, representing the leading publications in the various countries of the world. Twenty-four of these are received through the good offices of the editor of *The Medical Journal of Australia*, 26 are donations of the publishers, and 23 are purchased from London.

This year the *American Journal of Syphilis* has been added, starting with vol. I, 1917; also the Victorian Government Gazette and Victorian Hansard.

We are in receipt of a number of volumes of the latest text-books, which have been reviewed in *The Medical Journal of Australia*. Donations of valuable books and journals have also been received from Drs. A. V. M. Anderson, W. Kent Hughes, John Ramsay, Herman Lawrence, and from the library of the Medical School, Melbourne University.

We regret that some of our sets of journals have been broken through the thoughtlessness of a few members, who have removed them from the shelves without making an entry in the register kept for that purpose. Some bound volumes recovered this year have been missing for 16 and 18 years. We ask that the rules of the library shall be strictly observed.

A number of duplicate sets of journals and text-books, more or less out of date, are occupying valuable space upon our shelves. We were able to complete a number of sets of journals for the New South Wales Branch recently, and would be willing to do a similar service to the libraries of any other Branch.

During the year, at the request of the Bureau of Science and Industry, a complete card index catalogue of all periodicals on our shelves has been compiled. It will be incorporated in the larger catalogue of scientific journals now nearing completion by the Bureau of Science and Industry.

ALLEN ROBERTSON, }
H. DOUGLAS STEPHENS, } Honorary Librarians.

Presidential Address.

Professor R. J. A. Berry read an address entitled "One of the Problems of Peace: Mental Deficiency" (see page 485).

A cordial vote of thanks was accorded the retiring President for his important address, and for his valuable services to the Branch during the two years of office.

A meeting of the Victorian Branch was held on December 2, 1918, at the Commonwealth Serum Laboratories, Professor R. J. A. Berry, the President, in the chair.

Professor Berry outlined the discussions that took place at the conference held on November 26, 1918 (see *The Medical Journal of Australia*, December 7, 1918, pages 482-483).

Dr. J. H. L. Cumpston, Director of Quarantine, gave an account of the action taken by the quarantine authorities and of the position obtaining.

It was resolved that Dr. Cumpston's speech should be printed and circulated to all members of the Branch.

Dr. W. J. Penfold, the Director of the Commonwealth Serum Laboratories, gave a demonstration of the methods of preparing vaccines.

Dr. Philip Sidney Parkinson (M.B., 1914, University of Sydney), of 130 Edwin Street, Croydon, has been nominated for membership of the New South Wales Branch of the British Medical Association.

SIR ALFRED KEOGH, G.C.B.

The Federal Committee of the British Medical Association in Australia resolved at its meeting held on April 25, 1917, to address a letter to General Sir Alfred Keogh, then Director of Medical Services, to congratulate him in the name of the medical profession in Australia, on the occasion of his having received the distinction of the Grand Cross of the Bath, a distinction that had not previously been conferred on any member of the medical profession. Unfortunately, the message miscarried, and on learning of the fact, Sir Alfred wrote to Colonel W. T. Hayward, the Chairman of the Committee expressing the hope that a copy would be sent to him at a later date. The Federal Committee recognizing that Sir Alfred Keogh wished to preserve the letter in his family, gave instructions for the letter to be suitably engrossed; this document was duly sent to England. Colonel Hayward has received the following letter of acknowledgment.

Imperial College,
South Kensington, S.W.7,
September 10, 1918.

Dear Colonel Hayward,—

To merely say that I am pleased at the receipt of the engrossed letter containing the resolution of the Federal Committee of the B.M.A. in Australia, would be very

inadequately to express my feelings. I am deeply moved by the steps which have been taken to give me a permanent record of the congratulations of my late colleagues, and the document is one of my most treasured possessions.

No one can have a higher reward for his efforts than the approval of expert colleagues, who are aware of the difficulties which any member of the medical profession must encounter who endeavours to secure such changes as will enable the profession to advance the public interests. To know that whatever attempts I have made in this direction have secured the approval of the Federal Committee is intensely gratifying to me and mine.

Let me, therefore, through you, offer my warmest thanks to your Committee for the pleasure they have given me and for the honour they have done me.

Believe me,

Yours very sincerely,

ALFRED KEOGH.

Dr. L. W. Lambert, a member of the International Health Board of the Rockefeller Foundation, has arrived from America for the purpose of assisting Dr. J. H. Waite in the hookworm survey in Northern Queensland.

Obituary.

JOHNSTON HUGHSTON.

On September 14, 1918, Major Johnston Hughston was struck by shrapnel while in action in Macedonia, and died a few hours later. The details of his career can be told in a few words, but notwithstanding the short duration of his adult life and the paucity of landmarks in its course, the medical profession may well include his name among its most illustrious members. Johnston Hughston was a student at the Melbourne University, and a very popular student, both with his colleagues and with his teachers. He graduated in 1915, taking the medical and the surgical degree. In April of 1915 he offered his services to the Imperial authorities, through the Department of Defence, and went out as a Lieutenant in the Royal Army Medical Corps. The first three months were spent in Eastbourne, in the south of England, at the training camp. He was then sent to France, and did sterling work, which brought his qualities prominently before those in superior rank. In October, 1915, the Salonica Army was sent to Macedonia, and he obtained a position attached to the 67th Field Ambulance. In Macedonia he performed his duties with distinction, and at the end of twelve months he was promoted to the rank of Captain. He remained in the field when he might have arranged an exchange, as he recognized that there was a great dearth of medical men who knew the district, who could cope with the dangers of the climate and who could be relied on to reduce the risk to our troops in a most difficult campaign. He stayed on, working pluckily and energetically throughout 1916 and 1917. His brother officers, both in the Royal Army Medical Corps and in the combatant force, held him in the highest esteem, and in the old country his excellent reputation as an invaluable officer was widely spoken of. Early in 1918 he returned to Australia on furlough. He was weary, and a wreck from malaria, but his keen sense of duty impelled him to return to Macedonia. He said that every man was essential over there, and, regretfully, his fond mother was compelled to acquiesce. With pride in her heart she recognized that her son possessed the qualities of greatness, and she, too, made one of those supreme sacrifices which have characterized the noble women of the British Empire. On his return he was promoted to the rank of Major. On August 3, 1918, he was wounded by a spent shell fragment, and sustained a horrible gash in his chest. He was in hospital for a month, and then returned to his field ambulance. On September 14, 1918, he was struck down by shrapnel, and did not rise again. One of his brother officers has designated him "a very gallant English gentleman." The sympathy of the medical profession has been extended to his mother, and this feeling is tempered by the recognition that her son was magnificent in his life and in the performance of his duty.

Correspondence.

STANDARD OF MEDICAL EXAMINATION.

Sir,—The following are the questions given in the pass examination paper in regional and applied anatomy on November 26 for fourth year medicine at the University of Melbourne:—

1. Describe the spleen under the following heads:—
(a) Vascular supply.
(b) Lymph drainage.
(c) Anatomical relations.
(d) Diagnosis of enlargement.
(e) Surgical method of removal.
2. Describe the capsular ligament of the knee-joint. Indicate the injuries to which the menisci are liable and the surgical approach to them.
3. Describe from a surgical anatomy point of view the symptoms which arise in fracture of the skull in (a) the anterior, (b) the middle, and (c) the posterior cerebral fossæ.
4. Enumerate the muscles of the forearm and hand and give their nerve supplies.
5. Give details of an operation for ligation of the vertebral artery.

I suppose comment is needless, but it is difficult to appreciate the value of such a standard of knowledge to fourth-year students and who are prospective general practitioners.

Is such a paper set with the idea of causing students to learn the necessary elements of surgical anatomy—the conception of what are the necessary elements would, of course, vary with a person's sense of proportion; or, is such an examination evolved for the purpose of ascertaining whether students have explored and retain at their minds' command the very extensive fields both of anatomy and surgery.

One very important aspect is that, though we appreciate the great help such learning would be in a post-graduate course, yet it means a great sacrifice of much valuable hospital work, in order to strive to successfully cope with such a paper.

It suggests the possibility that persons who have too much power in their own departments may over-estimate the value of their particular branch of learning, to the detriment of the students.

Yours, etc.,

"FOURTH YEAR."

Melbourne, November 29, 1918.

Medical Appointments.

Dr. Stanislaus Emil Antony Zichy-Wolnarski (B.M.A.) has been appointed a public vaccinator for the North-Eastern District, Victoria, in the place of Dr. W. E. Tulloh (B.M.A.).

Dr. Herbert Evans (B.M.A.) has been appointed Part-time Medical Inspector of Schools, Townsville, in succession to Dr. W. B. Chapman, who has recently resigned his position.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 439 Strand, London, W.C.

Branch.	APPOINTMENTS.
TASMANIA.	
(Hon. Sec., Macquarie Street, Hobart.)	Medical Officers in all State-aided Hospitals in Tasmania.

Branch.	APPOINTMENTS.
VICTORIA.	
(Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other contract practice. Australian Prudential Association Proprietary, Limited. National Provident Association. Mutual National Provident Club.
QUEENSLAND.	
(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Cloncurry Hospital.
SOUTH AUSTRALIA.	
(Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments in South Australia. Contract Practice, Appointments at Renmark.
WESTERN AUSTRALIA.	
(Hon. Sec., Health Department, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES.	
(Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Parramatta, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION.	
(Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

- Dec. 17.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Dec. 19.—City Medical Assoc. (Sydney, N.S.W.).
Dec. 20.—Q. Branch, B.M.A., Council.
Dec. 26.—S. Aust. Branch, B.M.A.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.
All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.